The Modern Hospital

FEBRUARY 1954

President Eisenhower's Health Program • Prototype Study: 25 Bed Hospital • Blue Cross Problems • Minority Report on Tissue Committees • Unnecessary Use of Blood • How to Lead Group Discussions • Finance Commission Report

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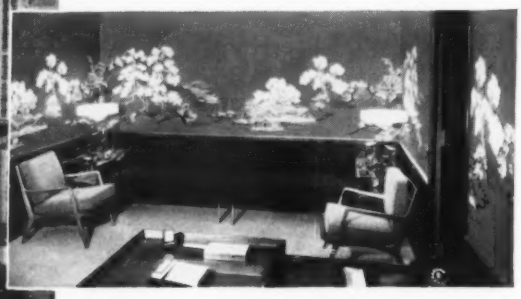

Typical business office reception room in Houston's new ultramodern Melrose Building

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• Combining dramatic exterior appearance and spacious, pleasant interior work space, the new MELROSE BUILDING in Houston, Texas, is an outstanding example of new architectural thinking. On two sides of this 21-floor office building sunshades extend four feet beyond horizontal continuous windows which are emphasized by spandrels faced with reflective blue-green tile. To establish maximum rental areas, elevators are placed along one of the brick, windowless walls and service areas along the second. Reduction of sky glare added to air conditioning provide a high degree of work comfort. SLOAN *Flush* VALVES, famous for efficiency, durability and economy, were selected for installation throughout the fine Melrose Building—more evidence of preference that explains why . . .

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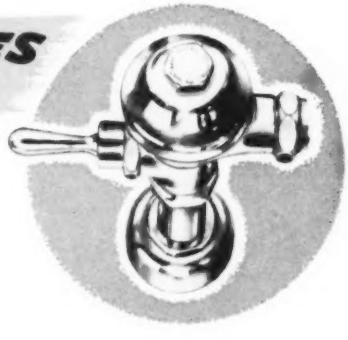
are sold than all other makes combined



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The Hausted Manufacturing Company Announces A New Sales Policy

As a business grows, its methods of doing business must grow with it. We have reached a point in our own growth where we are making a change in our sales program that, we are convinced, will enable us to serve our customers better. We have decided, therefore, to adopt a policy of *direct factory to hospital selling.*

Our main interest in adopting this *direct-selling* sales policy is to give every hospital the maximum in service at a minimum in price.

The Hausted line of Wheel Stretchers have become the quality line in their field—ranging from the regular Standard Stretcher to the Multi-purpose O.B. and Examining Table and the One-Way and Two-Way Slide and Tilt Easy-Lifts. In addition to our high quality in materials and manufacturing methods we are vitally interested in the high quality of use that hospitals receive from our stretchers.

We have found that we can maintain these high standards of quality better and even add to them when we are in *direct contact* with our hospital customers. Therefore, *we will now sell and service our customers directly from our factory.* We know that this will result in real advantages to the hospitals now using our equipment and to the hospitals who will join these hundreds of others that have increased their wheel stretcher efficiency through the use of the Hausted equipment.

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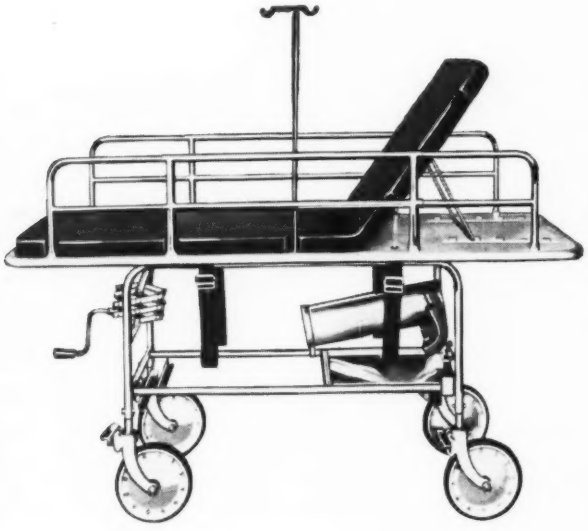

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For Information Contact Us Direct

THE HAUSTED MANUFACTURING COMPANY

Medina, Ohio

The Modern Hospital

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FEBRUARY 1954

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AMONG THE AUTHORS


George W. Wood

George W. Wood on page 80 describes the modernization of the admitting department of St. Francis Memorial Hospital, San Francisco, where, at the time he wrote the article, he was a resident in hospital administration. Recently, Mr. Wood became administrator of Antioch Community Hospital Association, Antioch, Calif. He has completed his undergraduate work at Stanford University and received his master's degree in hospital administration and public health from the University of California.


Betty W. McNabb

Betty W. McNabb, chief medical records librarian at Phoebe Putney Memorial Hospital, Albany, Ga., in the article on page 76, discusses the responsibilities of administrators and doctors concerning medical records. Mrs. McNabb received her A.B. from Florida State University, an M.A. from the University of California, and did further graduate work at the University of North Carolina, in addition to attending the Medical Records Institute at Milwaukee. Her career began at St. Vincent's Hospital in Jacksonville, Fla., and later she attended to medical records for the army while serving in the W.A.C. as a noncommissioned officer in charge of surgical records at Camp Butner, North Carolina. Active professionally as a consultant to the state of Georgia's division of hospital services, president of the Georgia Medical Record Librarians, first vice president of the American Association of Medical Record Librarians, past president of the Southeastern Conference of Medical Record Librarians, and chairman of the group supervision committee of the American Association of Medical Record Librarians, Mrs. McNabb also enjoys small boat sailing and basketball, as well as piloting her own plane back and forth from consulting assignments.

S. M. Rabson, director, department of pathology, St. Joseph Hospital, Fort Wayne, Ind., turns in a one-man minority report on the much discussed subject of the value of surgical tissue committees (*p.* 57). Dr. Rabson's views are based on observations as a pathologist which started in 1928-29 at Municipal Hospital, Vienna, Austria. After that time and before entering the navy, in which he served as a lieutenant-commander from 1938 until 1943, Dr. Rabson was an assistant pathologist at the tumor clinic of New York Postgraduate Hospital and at Columbia University. Prior to going to Fort Wayne, Dr. Rabson was a member of the staff of the New York City chief medical examiner.


Alan Fisher

Alan Fisher, designer of this month's "Hospital of the Month," comments on his project, Weld County Hospital at Greeley, Colo., on page 63. After studying at the University of Pennsylvania and M.I.T., and attending a summer session at the American School at Fontainebleau, Mr. Fisher spent some time traveling in France, Italy and Spain before going into partnership with his uncle, Arthur A. Fisher.

Dr. R. Sterling Mueller is a practicing surgeon in New York City and a member of the faculty at Columbia University's College of Physicians and Surgeons. A graduate of Columbia, Dr. Mueller served internships and residencies at Presbyterian and Bellevue hospitals in New York City and has been chief of the surgical clinic at Roosevelt Hospital. His article on the use of blood (*p.* 58) grew out of a paper on the same subject that he presented at a medical society meeting in New York a few months ago.

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★	Travert 10%-Electrolyte No. 1	80.0	36.0	4.6	63.0	60.0	—	2.8	—	Travert 10%	Any
★	Travert 10%-Electrolyte No. 2	57.0	25.0	—	50.0	25.0	—	6.0	12.5	Travert 10%	Any
	Ammonium Chloride 2.14%	63.0	17.5	—	150.5	—	70.0	—	—	Travert 10%	Any
	Darrow's	—	—	—	400.0	—	400.0	—	—	—	IV.
	M/6 Sodium r-Lactate	121.0	35.0	—	103.0	53.0	—	—	—	—	Any
★	Travert 10%-Potassium Chloride 0.3% in Water	167.0	—	—	—	167.0	—	—	—	—	Any
★	Travert 10%-Potassium Chloride 0.3% in 0.45% NaCl	—	40.0	—	40.0	—	—	—	—	Travert 10%	Any
		77.0	40.0	—	117.0	—	—	—	—	Travert 10%	Any

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Roving Reporter

"LONGLEY'S FOLLY"

It all started when I said, "Well, we *have* to have a storeroom!" A short time later, Mr. Jackson and Wilbur Davis arrived carrying some pieces of wood and a sledge hammer, and we staked our claim for a storeroom.

"Now, Sup," says Mr. Jackson, "quit waving your arms around in the air and get your ideas down on paper. Wilbur can make you some blueprints. Come to the next board of directors meeting with blueprints and a quotation. Then ask the board if they want to build this particular storeroom, or don't they?"

I asked Oscar Nelson to give us a bid on one, two and three stories, and quietly started my campaign to build three stories. It wasn't too difficult to get the board members up to the second floor—and the third was a cinch, since they realized that it would provide extra revenue. The original plan was to build the shell of the building and complete it as funds became available.

So one sunny day in November 1952 we signed a contract with Oscar Nelson & Son to build a wing on the west side of the hospital, 45 feet wide and 43 feet long and three stories high. Exterior construction was to be of brick and interior finish to be cement blocks, soundproof and fireproof ceilings, prefabricated floors with asphalt tile floor covering. The contract was to include electric, plumbing and heating equipment, floor covering and painting. The first floor (basement) was to be mainly storage rooms; the second floor was to provide extra office space, a new laboratory, examining room, E.K.G. and B.M.R. rooms; the third floor was to have five private rooms, three of which could be used as semiprivate, and one four-bed ward. A few brief instructions were given to the contractor, the main idea being stressed was not to let the "Sup" change her mind about anything.

We started the building the following Monday morning. By 10 a.m. I had decided to move the whole project about 10 feet to the south—one of the smartest decisions I made. The plumbing and heating contract was sublet to Earl Ayers & Sons. Mr. Ayers died the following week and his son Bob took over the responsibilities of our contract. Oscar Nelson took off for Arizona for the winter, leaving Bob in charge. Ralph Knudsen had the electrical contract, and our building program took on all the aspects of a "Youth in Action" program. And so we were in the building business, with a final quotation from Oscar Nelson & Son of $63,595—and a promise that they would refund any profits over 1 per cent.

The doctors soon referred to the project as "Longley's Folly" and implied that they had always thought I was a little nuts. My colleagues in the hospital field weren't very helpful either and began asking questions—Who was the consultant? Who was the architect? Where was the money coming from? *Life* magazine came out with a full page picture of a colored lady preacher, blueprints in hand, watching the workmen build her a Meetin' House. I received three copies

A surgeon tells you what he wants from a surgeons glove

"My grandfather remembers when they didn't have surgeons gloves—and then when they had them but no one wore them. Insistence on protection for doctor, nurse and patient has changed things since those days. Today, if I can get good sensitivity and comfort during long operations, I'm satisfied. Those two features, economy for the hospital, and protection are what I look for in a surgeons glove."

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THE SEAMLESS RUBBER COMPANY

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of this picture from friends who failed to sign their names. I began to have bad days and sleepless nights, but Wilbur and Bob acted as though they had been building hospitals for years.

Some days it snowed, some days it rained, some days the workmen didn't show up—but, even so, the building was growing. The flooring company came with its own crane and workmen and laid the first floor in about six hours. Eight working days later the second floor was laid. The spring rains came, but eventually the third floor and roof went on. Things really became rough when they started to make the opening between the new addition and the rest of the building—air hammer, dust, plaster and what have you. The patients were wonderful, but Gus, our maintenance man, cracked under the strain and said he had to have a two weeks' vacation. He stayed away a week and one day and is still not on speaking terms with the workmen.

It was time to sell our first government bond, and our finance chairman was crushed to find that a $10,000 bond was only worth $9950. She took turns blaming the Korean War, the Republican Administration, the Federal Reserve System, and the Ludington State Bank.

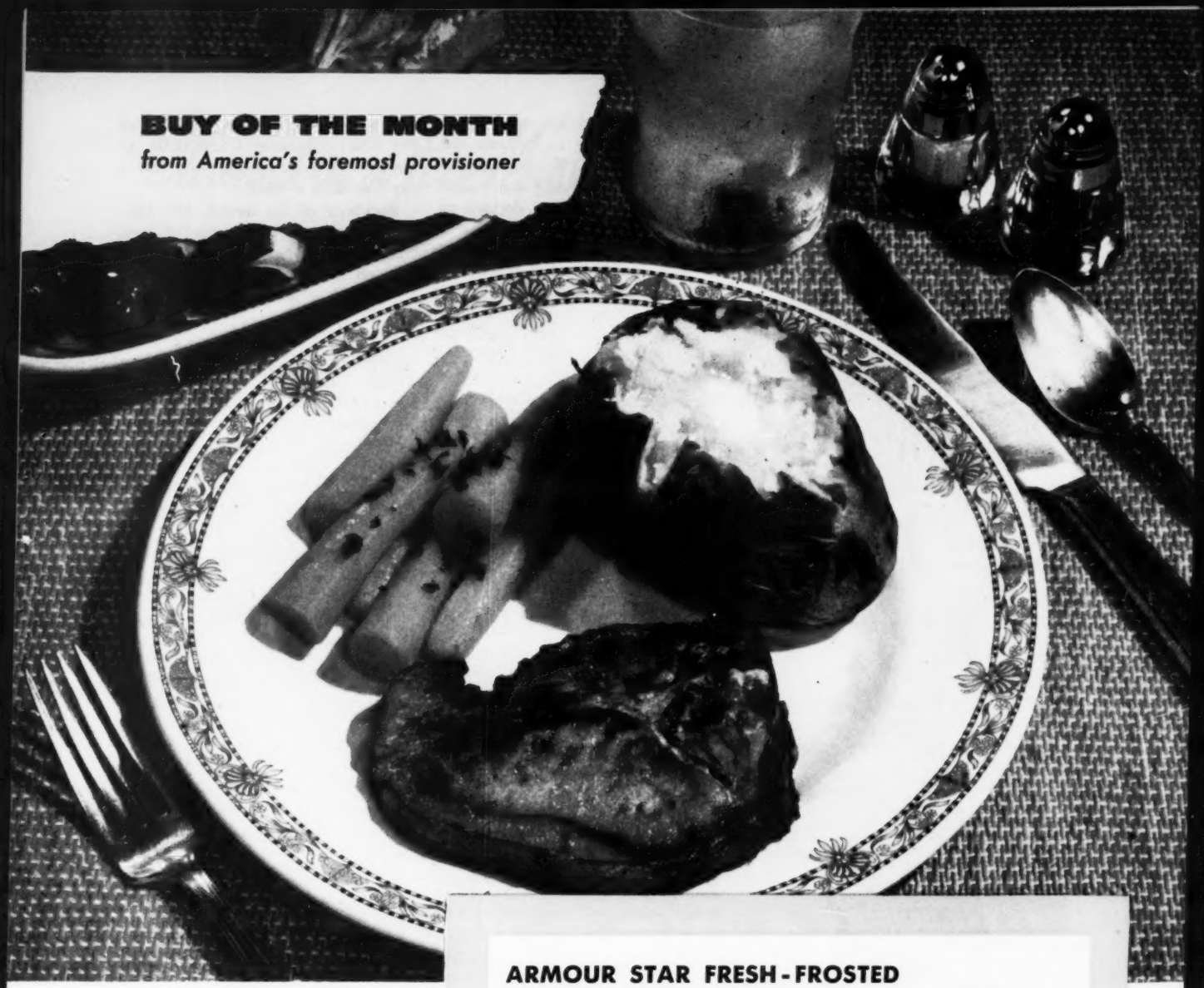
Bob Ayers got a strep throat and got behind in the plumbing. Fourth of July came and the workmen took a few days off. So did the nurses. Bob Nelson brought his 7 year old son along with him on a few inspection trips—said it was nice to have someone around he could boss.

I compromised with Galinski, the housekeeper, on the floor covering—tan for the rooms which wouldn't show dust and red for the corridors. The painter came up with a good shade of green and we decided to paint all the walls green—except my office. Wilbur said, "Let's put red in there. It will make the room look smaller." We also decided that my $1500 oil painting would be perfect for the east wall of my office. A friend bought this painting in a London art gallery for his first wife; his second wife gave it to me after a series of circumstances too complicated to relate here. After a conference, we bought a bolt of 99 inch unbleached sheeting and made draperies for all the rooms. I made a trip to a near-by manufacturer's to talk about furniture.

Even I had to admit that the financial picture looked a little bleak. We had a conference and came up with the idea that local industries would help finance our project. We decided to shake down Mr. Jackson for $10,000 and made an appointment to see him the following morning. "Well," said Mr. Jackson, "the money has to come from some place. The Sup really got us into something this time. We start to build a storeroom and end up with a $65,000 building program. Put me down for $15,000—and I'm sure the other industries will help."

We made a few other calls and had our $40,000. One industrialist jokingly asked if we didn't have things a bit in reverse. Wasn't it customary to raise the money and then build the building? We explained that our system was better. This way, you could see exactly what you were paying for. The women's auxiliary contributed $5700 with no strings attached. The furniture manufacturer proved that the editorial in The MODERN HOSPITAL was correct when it said, "The hospital supply companies give generously to the hospitals in their own communities."

We had a monthly board meeting, and the board decided that we should have Open House. While we were



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From package to plate – quick as a wink!

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Order ahead! They're quick-frozen—and that means their original fresh flavor is sealed in. Also, you know your exact cost per portion *in advance*, because each chop is uniform in size. Packed in convenient 10-lb. boxes, they're easily stored—quickly removed.

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getting things lined up, we realized that we would have to decorate the nurses' dining room. We had just installed soundproof ceiling and ruined the decor. We, or rather I, decided on yellow (Galinski hates yellow). It took three coats of paint, as Galinski predicted it would.

Then my Irish ancestry and Galinski's Polish ancestry got to fighting about what the second color should be. Danny, our Mexican janitor, got into the arena long enough to suggest just a few touches of red here and there.

On a Friday we cleaned and transferred the $1500 picture to my new office. Saturday morning, Wilbur, Bob Nelson, Danny and I had a consultation as to how the picture should be hung. The hanging took place at 12 o'clock noon. At exactly 12:30 p.m. it crashed to the floor. The picture and the glass were okay but the frame was a little beat up. My first reaction was to cover the hole in the wall with a calendar, but I changed my mind and spent Saturday afternoon listening to the football game sprawled out on the office floor repairing the picture frame. Into this cozy little setting came one of the high school girls to ask for a raise.

The Open House was a big success, the board members beaming as they greeted the guests, Wilbur Davis and Bob Nelson taking their bows, the auxiliary serving coffee in the yellow dining room, and the Sup—wearing red roses sent by the office force—fairly bursting with pride. Longley's Folly was completed, and Ludington liked it.—ELLA K. LONGLEY, *superintendent, Paulina Stearns Hospital, Ludington, Mich.*

Medical Motor Service

Hospitals and health agencies of Rochester, N.Y., enjoy a unique community resource, called Medical Motor Service. It exists solely to provide free transportation to civilian ambulatory patients who need medical care but have no means of reaching clinics.

Medical Motor Service, according to Joseph Mastroianni, administrative assistant at Strong Memorial Hospital, Rochester, is an organization headed by a board of 27 members elected for a term of three years; nine are chosen each year. Members of the board may be reelected, and continuity and smoothness of operation are aided by the fact that many members have served several terms. An office is maintained through the courtesy of the Child Guidance Clinic, and an executive secretary is on duty half a day five days a week.

Backbone of the service, Mr. Mastroianni writes, is a corps of paid women drivers who operate the three cars owned by the Medical Motor Service. One driver works full time five days a week, and the other two cars are operated by drivers who alternate their weeks of work. A list of substitute volunteer drivers is provided, a condition regarded as essential for such a program.

For efficient operation, it has been found necessary to buy one new car each year, Mr. Mastroianni declares. No garage is maintained and the drivers house the cars. Expenses are limited to salaries of the drivers, the half-time secretary, the cars and their upkeep, and printing and stationery needs. Annually the budget runs approximately $12,000. While the service has a membership of 450 with dues of $1 per year, the major portion of funds comes from the Community Chest.

Monroe County, which is served by Medical Motor Service, contains 673 square miles, but the majority of patients are within the city of Rochester and its adjoining suburbs.

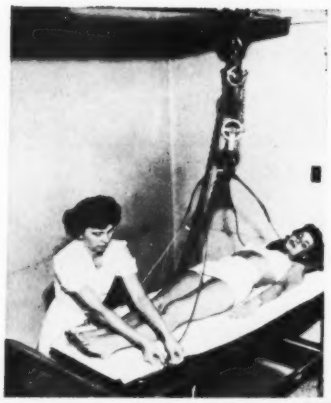
For some patients, one treatment and one trip suffice; for others treatments may be necessary for a period of years. In addition to increasing the scope of local clinics, the service frees hospital beds by enabling the patients to be discharged sooner because they can be brought back for follow-up treatments.

Growth of the work has been great. In 1946 the motor service made 4113 trips, carrying 2152 patients, for a total mileage of 19,684. In 1952 there were 12,185 trips for 6282 patients and a mileage of 54,041.

Most patients are referred to Medical Motor Service by the social service departments of the various hospitals, but calls are also accepted from other health and social agencies.

"Medical Motor Service has found that maximum efficiency is achieved by employing paid drivers and by operating its own cars," states Mr. Mastroianni. "To render proper service, the drivers must limit their efforts to bringing patients to clinics and to returning them home after treatment. Time spent by the drivers inside the clinic reduces the number of patients who can be transported."

Cleaned in a Few Minutes...READY FOR NEXT PATIENT



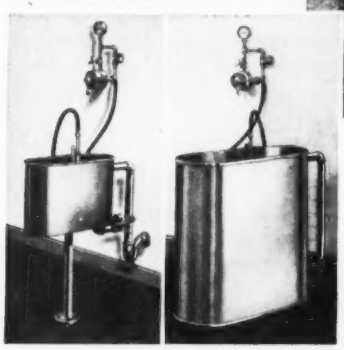
Blickman stainless steel equipment with seamless, round-corner construction, speeds service in Hydrotherapy Department

● This stainless steel underwater treatment tank can be thoroughly cleaned and made ready for the next patient in a matter of minutes. All surfaces are smooth and continuous. There are no seams, crevices or joints of any kind. The highly polished stainless steel reduces adhesion of dirt and grime. Cleaning takes far less time and effort, because all corners and intersections are fully rounded. Complete asepsis is attained with a minimum of labor. This means that you save money every day you use this long-lasting unit. That's why so many leading hospitals have standardized upon Blickman-Built hydrotherapy and physiotherapy equipment in sanitary stainless steel. We invite you, too, to *investigate and compare*, before you buy.

ABBOTT Model I-Beam Hoist of all stainless steel remains free of rust and corrosion, no matter how much hot, moist steam arises from the hydrotherapy tank.

HOT SPRINGS Model Underwater Treatment Tank—as used in St. Mary's Hospital, E. St. Louis, Ill. Designed for ready access to all parts of patient's body. After each treatment, tank is drained, scrubbed and brushed with surgical soap. Cleaning is easy because of the polished stainless steel surfaces and the round-corner construction. Aerators circulate water through pressure action, not by electrical means. Danger of shock is eliminated.

Below, left to right: HARVEY Model Stainless Steel Arm Bath permits patients to tolerate higher water temperatures as air is introduced to give swirling motion. RADCLIFFE Model stainless steel leg bath provides a whirlpool action proved efficacious in treating local areas to stimulate circulation.



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You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass. March 29-31.

Modern Art for Mothers

Modern art set Marin County residents agog recently when Marin General Hospital, near San Francisco, opened its doors to its first patient—a woman in labor.

Gordon Onslow-Ford, well known muralist, upon completion of his work on the walls of one of the labor rooms, said: "I have tried to create an atmosphere where women in labor will be transported into a world of vision where their pain and anxiety are minimized."

Not all of the residents of Marin who visited the hospital on its opening day understood the significance of the circles, squares and curves and the lines that run into distant perspectives like a railroad track fading away into one line at the horizon. The artist declares that the mural does not represent anything specific and that the mother in labor is free to see in it anything she wants to. In order to obtain patient reaction the hospital provides a printed card on which a brief story of the mural is told, with space at the bottom for patient comment. Quiet conversation on the subject

An OB nurse and the administrator study the much discussed mural on the labor room wall of the Marin General Hospital.

with the mothers-to-be in various stages of labor bring reactions ranging from mild, restful hypnosis to concerted interest, which sometimes is thought to lessen the fear and pain factor. One patient, however, referred to the work of art as "a bizarre tracing which possibly would appeal to someone at the 4 or 5 year old level." This patient had the feeling that "all has been lost in a fulminating debacle." Along with two or three negative reactions, there have come many delightful, humorous and constructive responses. Virtually everyone attempts to bring the myriad contrasting shapes and lines back into levels of reality. Their difficulty, many agree, is their inability to point out to their husbands at the bedside their recognition of material forms.

Most interest comes from the obstetricians themselves. It is not difficult, upon careful viewing, to see why these doctors make a clinical approach to the forms on the walls. They liken the circle effects to those found in labor progress graphs on the medical chart and other lines and shapes to temperature lines and pathology patterns seen under the microscope.
—WILLIAM S. WEEKS, *administrator, Marin General Hospital, San Rafael, Calif.*

Music With Their Meals

Negro employes at Baptist Memorial Hospital, Memphis, Tenn., were asked to take part in a clean-up drive. They went at the task with such vigor and the results were so impressive that Dr. Frank S. Groner, the administrator, and the board decided to reward them. The reward: piped music in the employes' dining room. Now the workers eat their meals in a pleasant and relaxing atmosphere.

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Extra protection against slipping—so important for patients and busy staff members—is assured with floor wax containing anti-slip "Ludox." The unique snubbing action of the "Ludox" particles heads off a slip before it can start. And because these particles are tough and transparent, wax films are harder . . . have added depth of luster.

All these advantages are added at no sacrifice to the basic properties of high-quality wax. Properly formulated waxes containing Du Pont "Ludox" take a high gloss and have excellent water resistance and leveling properties. It will pay you to investigate these new waxes. Ask your maintenance man to get a sample of floor wax containing anti-slip "Ludox" from your wax supplier. One trial will convince you!

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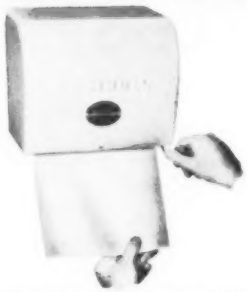
COLLOIDAL SILICA

DU PONT

REG. U.S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

eliminate towel waste with WESTROLL!



The Westroll towel dispenser has relatively few working parts, so its maintenance factor is negligible. Westroll dispensers are streamlined, easy to keep clean. They assure a constant supply of towels, help keep washrooms spic and span, save costly janitors' time.

It's human nature to take advantage of an overly generous paper towel dispenser. Particularly so with interfold or flat towels where two, three or even four are used for one drying. But with Westroll, people tend to take just enough and no more. You save as much as 40% on towel costs.

Tests show Westroll users average only 17 inches of paper, against 22, 33, or 44 inches of interfold. Users can crank out exactly the amount of towel necessary – even as little as two inches for lipstick removal! These are immediate savings.

You also save on maintenance. One filling of a Westroll micromatic dispenser is equivalent to *four* fillings of the ordinary flat-towel dispenser. Westroll dispensers are loaned and maintained by West.

Westroll towels are outselling our interfold towels 20 to 1. No customer has ever switched back to interfold towels after trying Westroll!

WEST DISINFECTING Company

42-16 West Street, Long Island City 1, N. Y.

WANT DETAILS?

Tear out this coupon and mail with your letterhead

Dept. 12

I'm interested in:

☐ A FREE leaflet on WESTROLL.

☐ A talk with a West expert about my washroom problems. No sales pitch. No obligation. Just discussion and a demonstration if I want it.

Space man with a down-to-earth viewpoint

THIS man specializes in x-ray space problems. They're the type of space problems you must take into consideration when planning installation of x-ray equipment in new or modernized facilities. At no cost and without obligation, a staff of layout experts at General Electric will help you or your architect plan every part of the installation down to the last detail — including protective requirements, power, wiring . . . even plumbing needs.

Available through General Electric's X-Ray Department, Milwaukee 1, Wis., or local district offices — this Installation Planning Service is just one example of how you get much more than equipment when you buy G-E x-ray apparatus. It's another reason why —

You can put your confidence in —

GENERAL ELECTRIC

6

of the many extra services you get from General Electric X-Ray

(1) INSTALLATION PLANNING SERVICE . . Expert layout of your complete x-ray facilities down to the last detail.

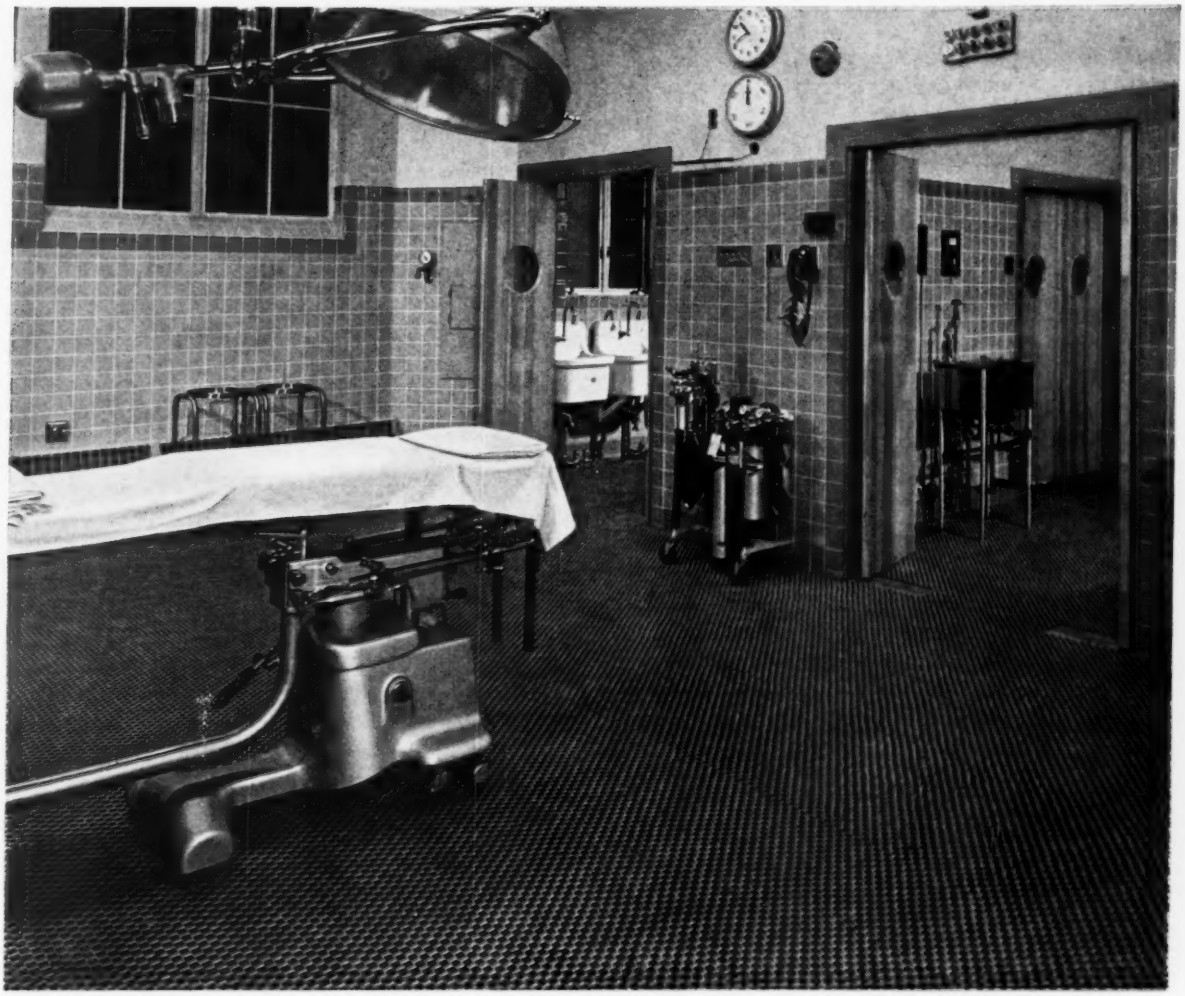
(2) TECHNICAL SERVICE . . . . . Operative technical experience available on latest technics and procedures.

(3) EMERGENCY SERVICE . . . . . Day or night — fast, factory-trained service and quality repair parts at your call.

(4) ENGINEERING SERVICE . . . . . Field service personnel are kept up-to-the-minute on latest equipment advances.

(5) MAXISERVICE® . . . . . You can *rent* G-E x-ray apparatus. No initial capital outlay, no obsolescence risk.

(6) SUPPLY SERVICE . . . . . Extensive local stocks of x-ray accessories and supplies at 68 field offices.



CONDUCT-O-TILE Eliminates Main Causes of Anesthetic Explosions

Static explosion is one of the most feared of operating room hazards. New Conduct-O-Tile reduces this danger by dissipating dangerous charges of static electricity.

Conduct-O-Tile, a vitreous ceramic tile, is *permanently* conductive. It needs no waxing or other special treatment. There is no free carbon to bleed out and be tracked to other areas.

Conduct-O-Tile floors and A-O glazed tile walls are recommended for operating rooms, delivery rooms, adjoining corridors, and areas where anesthetics are stored.

For extreme sanitation, for beauty, low maintenance and long service in many other hospital areas, specify American-Olean wall and floor tile. It's real clay tile!

American-Olean Tile Co.

Executive Offices: Lansdale, Pennsylvania
Factories: Lansdale, Pennsylvania • Olean, New York
Member, Tile Council of America

TILE SPECIFICATIONS FOR THIS OPERATING ROOM:

Color Plate 330. Main Operating Room, Palmerton Hospital, Palmerton, Pa. Floor: Caneweave; Jet Conduct-O-Tile, Green Granite. Walls: 14 Spring Green. Cap and Base: 15 Sylvan Green.

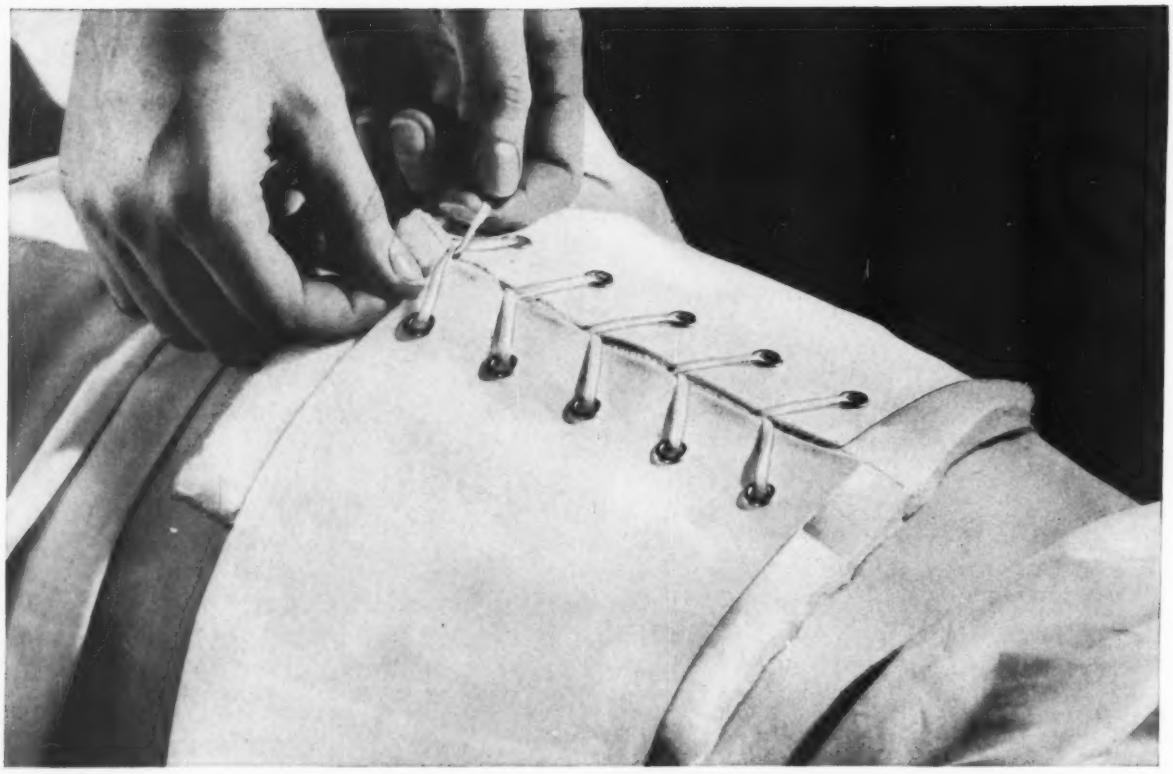
SEND FOR COMPLETE TECHNICAL DATA

Details on product, installation methods in new construction as well as in remodeling, and full specifications. No obligation, of course.

AMERICAN-OLEAN TILE CO.
967 Kenilworth Ave., Lansdale, Pa.

Please send me full information and free literature concerning Conduct-O-Tile.

Name.....
Title.....
Hospital.....
Address.....
City.....*Zone*.....*State*.....



Especially valuable in heavy drainage cases, *Curity* Ready-Made Adhesive Ties are easy to use for either "Montgomery straps" or "adhesive corsets." Simply cut lengths desired, apply adhesive section to skin, and lace dressing firmly over wound. To change dressings, just untie, replace pad and retie.

CURITY Ready-Made Adhesive Ties

SAVE ADHESIVE...SAVE NURSE TIME...SAVE MONEY

...with the finest Curity adhesive ever made.

Why waste adhesive—and add to patient discomfort—by replacing a complete adhesive strapping with each physician's examination or dressing change?

And why waste valuable nurse time making your own adhesive ties when *Curity* Ready-Made Adhesive Ties will *more than pay for themselves.*

Made with finest *Curity* Adhesive, these ready-made ties stay on for days . . . reduce your adhesive costs up to 95 per cent in heavy drainage cases.

New *Curity* adhesive mass gives added sticking power, yet comes off clean when removed. Helps eliminate tape shifting, corner curling and wrinkling without loss of desired flexibility. And you can't buy a *less irritating* adhesive!

Supplied in 5-yard rolls, both 9 inches wide (9 rolls per case) and 5½ inches wide (18 rolls per case), with metal eyelets at 1¼-inch intervals.

FOR STILL GREATER SAVINGS—1. Order your Adhesive Ties in combination with *Curity* Adhesive for best quantity discounts; and 2. make *Curity* Adhesive Ties widely available—the more they are used the greater the saving.

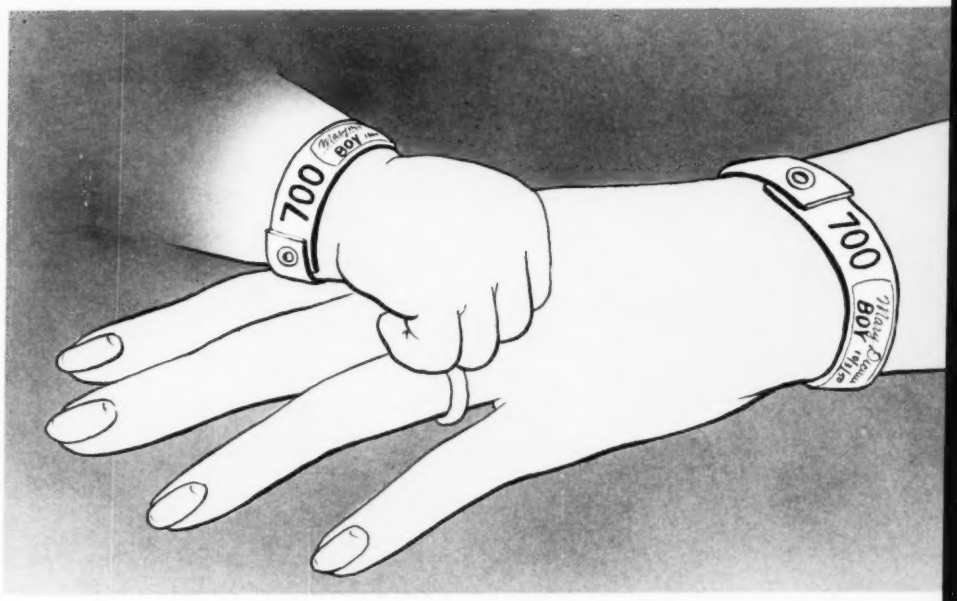
Curity
REG. U.S. PAT. OFF.

ADHESIVE TIES

BAUER & BLACK

Division of The Kendall Company
309 West Jackson Blvd.
Chicago 6, Illinois

Looking for Unalterable CORRELATED *Mother-Baby Identification?*



SECTIONS DIVIDED AFTER BIRTH—ONE (OR TWO AS REQUIRED) FOR BABY, ONE FOR MOTHER. ALL HAVE SAME NUMBER, COMPLETE BIRTH INFORMATION SEALED INSIDE.

Two sections for Baby's wrist(s) or ankle(s) . . . Provides two identifications on each newborn.

(Also available with single Baby band section . . . where only one identification on each newborn is required.)

700 HUBER MEMORIAL HOSPITAL Chicago Illinois ◆ BABY

700 HUBER MEMORIAL HOSPITAL Chicago Illinois ◆ BABY

Section for Mother's wrist . . . an integral part of Baby's band.

Separated here in delivery room ◆ —*after* birth

700 HUBER MEMORIAL HOSPITAL Chicago Illinois ◆ MOTHER

One Single Ident-A-Band® — Simply yet Positively Matches Each Baby with its Mother

Here is the easy, the simple, the perfect answer if you are seeking positive, foolproof, correlated mother-baby identification as recommended by the American Hospital Association and by the American Academy of Pediatrics.

One (and only one) pre-numbered Ident-A-Band is taken into the delivery room with the mother. *After* birth, the various sections are divided, cards containing complete birth information are then inserted, and the bands sealed on baby's wrists (or ankles) and the mother's wrist. This means the identification is absolute — mother and baby have identical, unalterable identification items applied right in the delivery room.

The soft Vinylite Ident-A-Bands are fast, simple and easy to use — comfortable and non-irritating to the patient. They are so designed that once sealed, they will not come off and they can never ever be used again for some other baby. An economical system for you too, for despite their positive nature, Ident-A-Bands actually cost less than most other identification methods.

Fill in and return the coupon today for samples and complete price information.

NAME _____

HOSPITAL _____

CITY _____

Please send me by return mail a sample HOLLISTER IDENT-A-BAND with detailed information at no cost or obligation.

Franklin C. Hollister Company GOODWILL BUILDERS FOR HOSPITALS

833 NORTH ORLEANS ST., CHICAGO 10, ILLINOIS

For this baby only the best will do

and she HAS *the best . . . . a Hollister Inscribed Birth Certificate*

Every new mother knows her baby is the most wonderful baby ever, and should always have the very best of everything. So you will want to be sure the Birth Certificate you present to her is the very finest obtainable—a Hollister Inscribed Birth Certificate, designed and produced especially for your hospital.

This Birth Certificate is a very important and greatly appreciated gift because it tells the new mother that you and your staff are personally interested in her new baby. It's a gift she will long treasure too—for it will remind her in the years to come just how friendly and thoughtful you were and how the care you provided for her baby was the very finest.

Send today for your free copy of the 1954 Hollister Birth Certificate Catalog which pictures and decribes all the various Inscribed Styles. Be sure to see the newly designed folder-style Certificates, the handsome designs for modern, rambling style buildings, the favorite traditional designs, and the new styles with beautiful religious motifs.

Franklin C. Hollister Company GOODWILL BUILDERS FOR HOSPITALS

833 NORTH ORLEANS ST., CHICAGO 10, ILLINOIS

Please send me, without charge or obligation, my copy of the new 1954 Hollister Birth Certificate Catalog and samples of the new styles and designs.

NAME _____

HOSPITAL _____

ADDRESS _____

THIS IS ANOTHER
in the continuing series of advertisements in national magazines for Seven-Up —the pure, wholesome drink that folks of *all* ages may enjoy.

Try a Stackwich* with chilled Seven-Up!

*How to stack a STACKWICH...

Cut a bun into four slices. Cut two franks (cold) lengthwise into three slices each. *Bottom layer:* franks with pickle relish. *Middle:* franks with baked beans. *Top:* franks with Swiss cheese and mustard. Serve cold—or warm in oven.

Stack one up soon . . . and make it extra wonderful with sparkling 7-Up, the crystal-clear drink that always goes so good with good eating. **You like it—it likes you!**

Get a family supply of 24 bottles. *Buy 7-Up by the case. Or get the handy* **7-Up Family Pack.** *Easy-lift center handle, easy to store. Buy 7-Up wherever you see those bright 7-Up signs.*

Cool HOT SUMMER COMING!

If You Specify EMERSON-ELECTRIC DELUXE Room Air Conditioners NOW!

Put the breath of spring inside your buildings all summer long. Install ½-, ¾-, or 1-ton Emerson-Electric Room Conditioners . . . and note the profitable results: your patients will be cool and contented.

Get the facts about this fine line of Room Conditioners.

Compare them with *any* on the market and you'll find they have the same quality of design and construction that has made Emerson-Electric the leader in the fan field for years. Write for Catalog No. RC22.

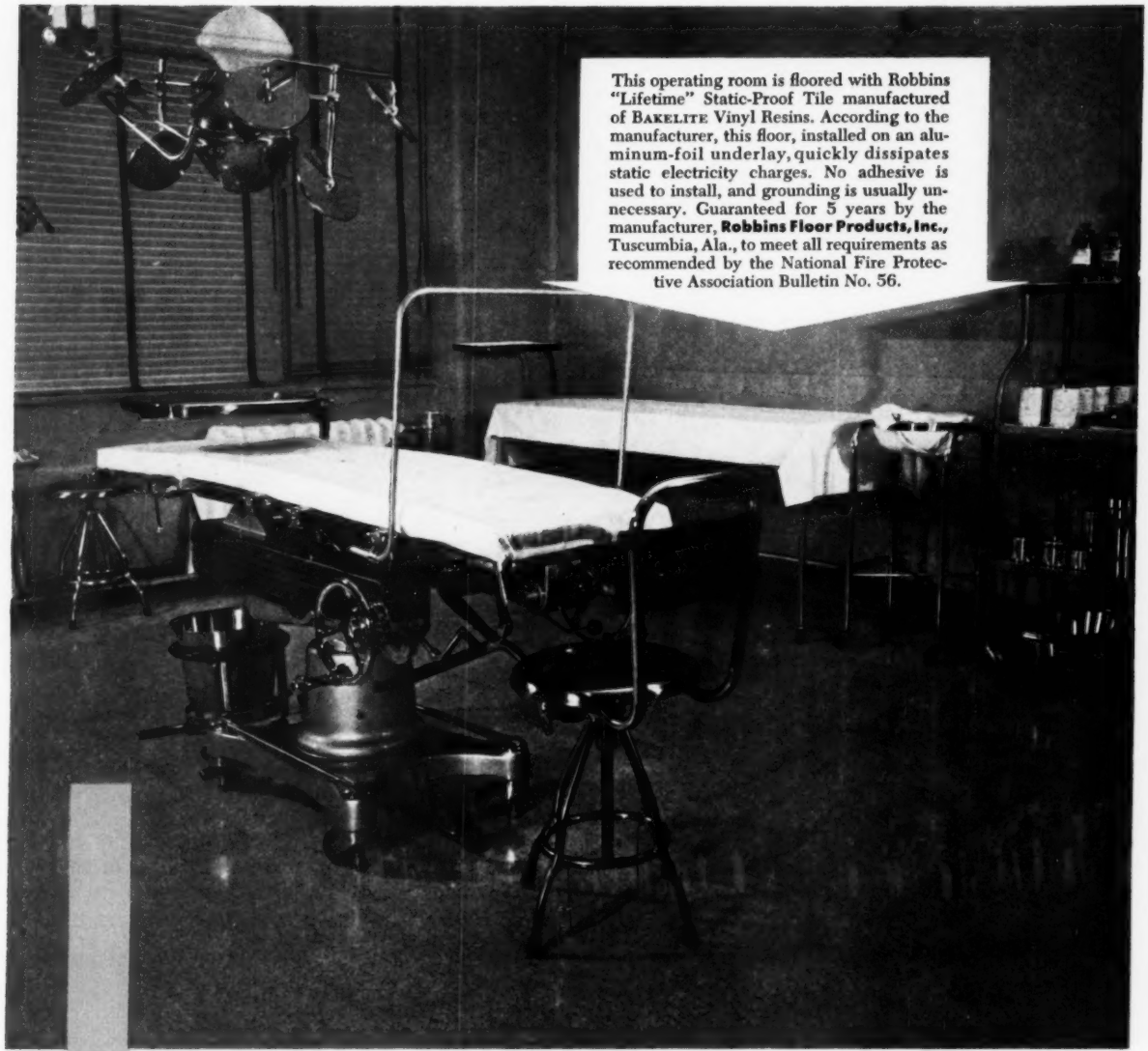
THE EMERSON ELECTRIC MFG. CO. • St. Louis 21, Mo.

Emerson-Electric fans mean cool summer comfort, too!

WINDOW FANS—Two-speed, reversible, in 16″, 20″, 24″ and 30″ blade sizes. Silver grey enamel finish. 5-Year Guarantee.

OSCILLATORS—10″, 12″ and 16″ overlapping blades, fingertip oscillation control, metalescent bronze finish. 5-Year Guarantee.

EMERSON ELECTRIC
FANS • MOTORS APPLIANCES



This operating room is floored with Robbins "Lifetime" Static-Proof Tile manufactured of BAKELITE Vinyl Resins. According to the manufacturer, this floor, installed on an aluminum-foil underlay, quickly dissipates static electricity charges. No adhesive is used to install, and grounding is usually unnecessary. Guaranteed for 5 years by the manufacturer, **Robbins Floor Products, Inc.,** Tuscumbia, Ala., to meet all requirements as recommended by the National Fire Protective Association Bulletin No. 56.

FLOORING for Safety, Service, Beauty

made of BAKELITE Vinyl Resins

TRADE-MARK

Today, with conductive flooring made of BAKELITE Vinyl Resins, greater safety can be assured . . . *plus* longer wear, lower maintenance, easy installation, and pleasing decorative effect of high light-reflecting colors.

Flooring made of BAKELITE Vinyl Resins is resilient, easy to walk on. Yet it withstands rough service, moving of heavy equipment. The surface is non-porous, resists scratches and mars. It resists soap, cleansers, ether, alcohol, blood, most acids, alkalies and other chemicals. Thus it cleans very easily. Maintenance is at a minimum. Service is maximum.

The same qualities make flooring made of BAKELITE Vinyl Resins the soundest investment for all rooms and corridors . . . for institutions, offices, industries and the home. For further information, write Dept. SW-85.

BAKELITE
TRADE-MARK
VINYL RESINS

TRADE MARK

BAKELITE COMPANY
A Division of
Union Carbide and Carbon Corporation
UCC
30 East 42nd Street, New York 17, N. Y.

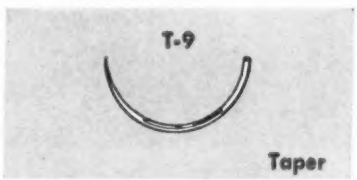
effortless suturing...less trauma with D&G extra-sharp ATRAUMATIC® needles for general closure

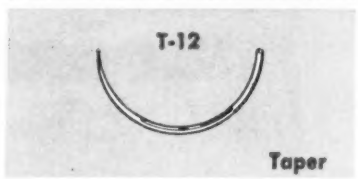
C-10, *three and one-half times enlarged*

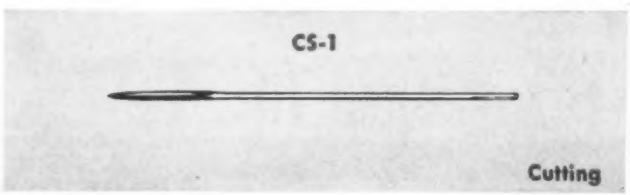
Did you know that these 9 temper-tested, hand-finished D & G Atraumatic needles are combined with a *variety* of suture materials? More and more surgeons use them for general closure and ob.-gyn. surgery because there is a fresh, sharp needle for each situation, no tug to clear the needle, less injury to tissues. Important, too—no threading, no dropped needles. Study the needles illustrated here and ask your suture nurse for your selections. D & G Atraumatic needle-sutures simplify inventory and save nurses' time.

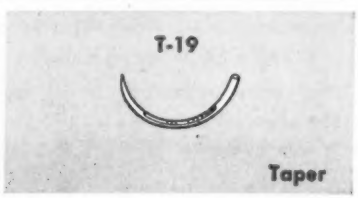
Atraumatic needles replace these eyed needles

Use ½ Circle Taper Point instead of: Mayo Catgut; Mayo Intestinal; Murphy Intestinal; Ferguson; Kelly.
Use ½ Circle Cutting or Trocar Point in place of: Regular Surgeons; Fistula; Mayo Trocar; Martin's Uterine.









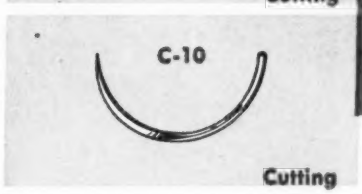
general closure sutures

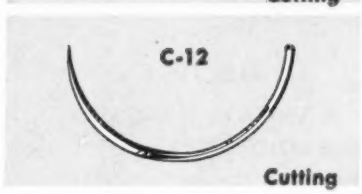
D & G "TIMED-ABSORPTION" SURGICAL GUT NON-BOILABLE:

No.	Type	Length	Needle	Sizes
1509	A, Plain	27"	T-9	00 to 1
1546	C, Med. Chromic	27"	T-9	000 to 2
1508	A, Plain	27"	T-12	00 to 1
1548	C, Med. Chromic	27"	T-12	000 to 2
1561	C, Med. Chromic	27"	T-18	000 to 1
1563	C, Med. Chromic	27"	T-19	00 to 1
1547	C, Med. Chromic	27"	C-9	000 to 2
687	C, Med. Chromic	27"	C-10	000 to 2
689	D, Extra Chromic	27"	C-10	00
685	D, Extra Chromic	27"	C-12	0 to 2
693	C, Med. Chromic	27"	R-1	00 to 1
691	D, Extra Chromic	27"	R-1	00, 0

ANACAP® SILK:

No.	Material	Length	Needle	Sizes
1378	Black Braided Silk	30"	C-9	000 to 1
1379	Black Braided Silk	30"	T-9	000 to 1
1380	Black Braided Silk	30"	CS-1	000, 00, 0
1397	Black Braided Silk	30"	T-12	000 to 2



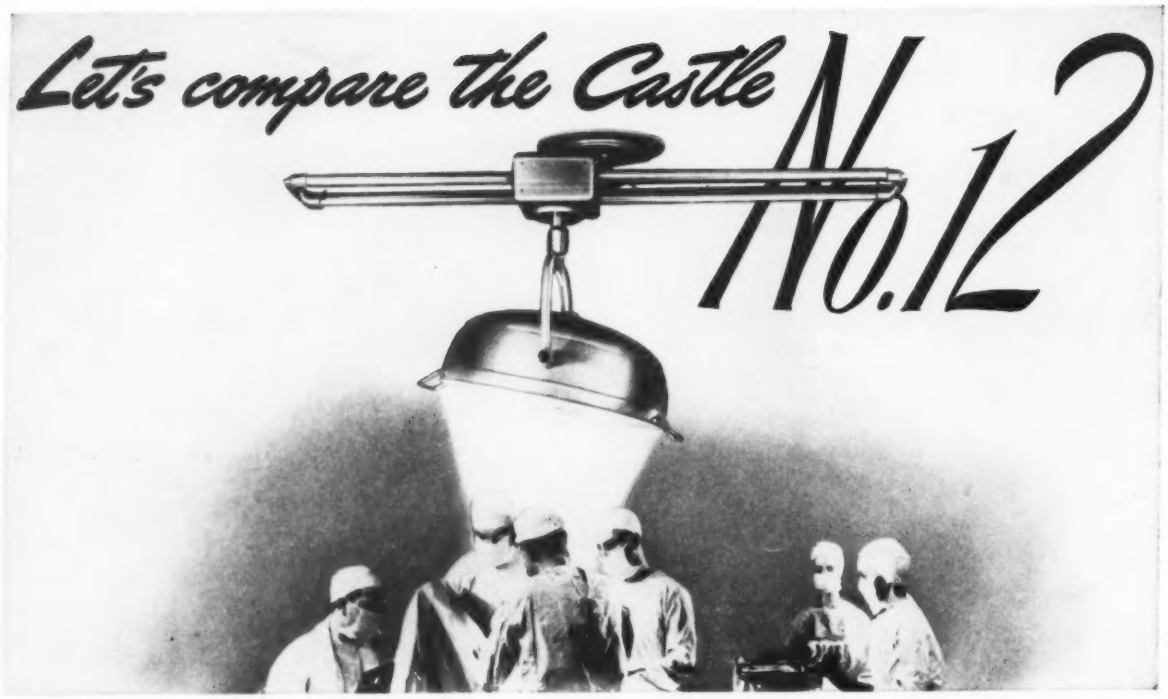


Need program material for staff meetings?
Request films from D & G Surgical Film Library.
Write for catalog.

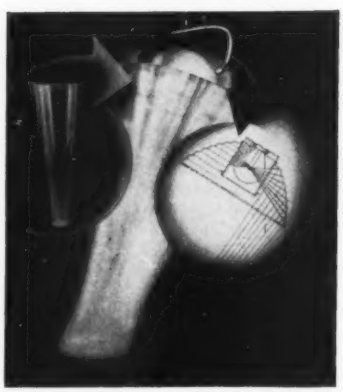
Davis & Geck INC.
a unit of American Cyanamid Company

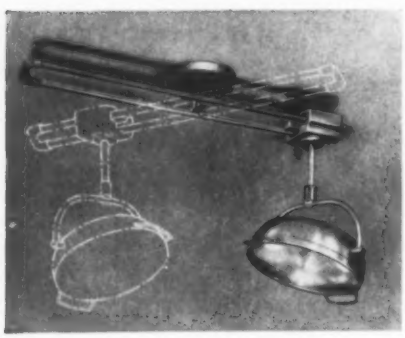
Danbury, Connecticut

Let's compare the Castle No. 12



First—a superior optical system which permits the utilization of lower intensities to provide uniform illumination of all deep cavity surfaces. Quality of light, with proper intensity, is the key to better vision. Conventional provisions for "step-up" intensities, which tend to produce contrast and eye-fatiguing glare, are eliminated as unnecessary . . . DEMAND CASTLE QUALITY.





When Light-dome is positioned at either extremity of the track mounting, no part of its assembly will penetrate the hazardous 5-foot-from-floor area in which explosion-proof equipment is mandatory. Constant apprehension and need to check this point for safety is completely eliminated . . . DEMAND CASTLE SAFETY.

Unsurpassed

- **SHADOW REDUCTION**
- **COLOR CORRECTION**
- **TEMPERATURE CONTROL**

With operating table at its lowest horizontal position, the Castle No. 12 Major Light provides a constancy of working intensity for an unbroken distance of 24 inches, extending from the light pattern at the surgical site towards the light source. This important feature compensates for varying tables elevations, and eliminates functional mechanisms for such adjustments . . . DEMAND CASTLE SIMPLICITY.

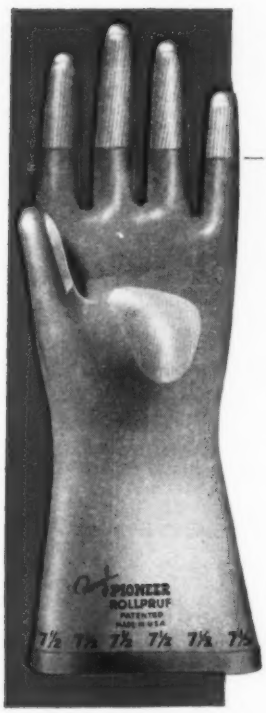
WRITE TODAY for complete information and catalog on scientific surgical lighting

WILMOT CASTLE COMPANY
1271 University Ave. Rochester 7, N. Y.

Castle STERILIZERS AND LIGHTS

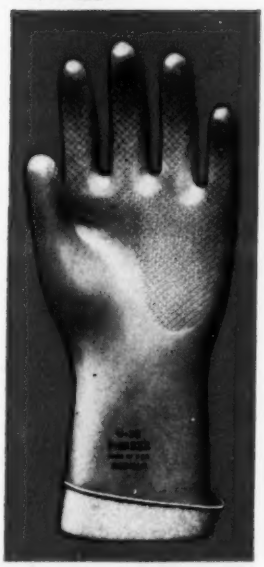
Announcing 2 New PIONEER Gloves

ROLLPRUF *Rough* Surgical Gloves



Extra Sure Grip for Surgeon's Fingers

PIONEER, maker of either-hand Quixam and Obstetrical gloves, Rollpruf and non-allergic neoprene Rollpruf surgical gloves, presents another important advance in surgical glove design—the RP-169R Rollpruf *Rough*. This new PIONEER *rough* texture grip on fingertips and palm provides easier, surer handling of instruments and moist tissue. Extreme sheerness gives utmost fingertip sensitivity—almost barehanded dexterity. PIONEER processed virgin latex retains high strength and elasticity even after extra sterilizations. Rollpruf's beadless flat-banded cuffs cling to surgeons' sleeves—no roll to roll down. Multi-Size markings printed across cuffs speed up glove sorting—save time and expense. Specify PIONEER Rollpruf *Rough* surgical gloves. Available at leading Surgical Supply Houses.



New Flock Lined, Soft —No Clammy Feeling

U-35 Medical Utility Glove...Ideal for non-surgical hospital housekeeping and autopsy...Neoprene—resists oils, acids, caustics, grease, detergents...Short curved fingers—roomy across palm and knuckles for working ease and comfort.

the PIONEER Rubber Company
350 Tiffin Road • Willard, Ohio

Makers of fine surgical gloves for 35 years

Special Diets? LET PRUNES HELP

First you prepare the diet. But then you face what is often a bigger problem—how to get the patient to *stick to it!* Here's where California Prunes are proving so especially helpful to dietitians.

Prunes' natural sweetness helps satisfy the "sweet tooth" without excess calories. And their high concentration of quickly assimilable sugars helps provide food energy to combat listlessness.

What's more, California Prunes help you maintain a *variety* of dishes and recipes. They are so easy to use so many ways.

LOW CALORIE

Prune Coffee Whip

- 1 envelope unflavored gelatin
- ½ cup cold water
- 1½ cups hot strong coffee
- 1 tablespoon liquid no-calorie sweetener
- ½ cup pitted, chopped prunes cooked without sugar (8 or 9 medium)
- Dash of salt

Soften gelatin in cold water; dissolve in hot coffee. Add liquid no-calorie sweetener and salt; chill until syrupy. Beat with a rotary beater or electric mixer until light and fluffy and doubled in volume. Fold in prunes. Spoon into sherbet glasses; chill until firm. Makes 4 generous servings.

Calories per recipe: Approximately 155
Calories per serving: Approximately 40

LOW SODIUM

Special Prune Muffins

- ½ cup chopped cooked prunes
- ½ cup granular whole-wheat breakfast cereal
- 1 cup liquid low sodium milk
- 1 cup sifted flour
- 6 teaspoons sodium-free baking powder
- 2 tablespoons sugar
- 1 egg, beaten
- 2 tablespoons salad oil or melted salt-free fat

Combine prunes and wheat cereal in bowl. Heat milk and pour over prunes and cereal. Sift together flour, baking powder and sugar. Add egg and oil to prune mixture and mix well. Stir in dry ingredients, mixing only until combined. Spoon into well-greased muffin pans. Bake in a moderately hot oven (375° F.) 30 minutes, or until done and brown. Makes 16 large muffins.

57.68 mg sodium in recipe
3.6 mg sodium in each muffin

NOTE: *For unrestricted diets use 4 teaspoons regular baking powder instead of sodium-free baking powder and add ½ teaspoon salt.*

Good eating *plus!* Don't overlook prunes' essential A and B vitamins, and their important supply of iron and other vital minerals. Still more reasons to include the "wonder fruit" *often!* California Prune Marketing Program, San Francisco, California.

So many ways to use delicious

the California wonder fruit **PRUNES**

NEW FACES...

M. C. STRICKLAND
President

AND A Swifter PACE

for famous products by

RICHARD C. REINHARDT
Vice President

MILWAUKEE LACE

Division of Smith-Lee Co., Inc.

The baseball Braves aren't the only big news out of Milwaukee. The Milwaukee Lace Paper Company, specialists in paper products since 1898, has been purchased by the Smith-Lee Co., Inc., of Oneida, N. Y., long-time leader in the manufacture of paper products for the dairy industry.

There are new faces — and the selling pace will be new and swifter, too. Expansion is already under way with the addition of new equipment and skilled personnel at both the Milwaukee and Oneida plants. Our combined production facilities now rank us as one of the nation's largest paper converters.

You can soon look for the famous "Milapaco" name on new packages and in new places, particularly at consumer level. You can rely on the same superior products, production skill and fair business practices so long a part of the Milwaukee Lace operation. And you can count on new, aggressive management to streamline distribution and service and to maintain a firm pricing policy insuring a fair profit for all.

We're sold solid on sales promotion and plan to use it intensively and intelligently to move more Milapaco merchandise. With a live-wire sales team and forceful advertising backed to the hilt with merchandising, we are geared for more sales and profits right down the line — including you and your customers.

We're going places! Won't you join us?

Milapaco

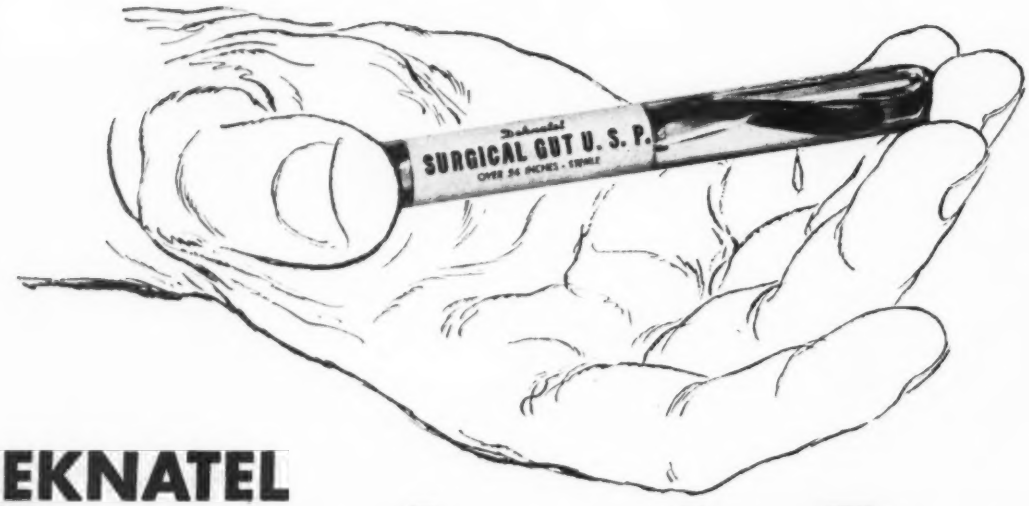
MILWAUKEE LACE PAPER CO.

Division of Smith-Lee Co., Inc.

1309 E. Meinecke Ave. Milwaukee 12, Wisconsin

SPECIALTY PAPER PRODUCTS OF CHARACTER SINCE 1898

now-



DEKNATEL Surgical Gut

Deknatel—famous for years as a synonym for the finest in surgical silk, cotton and nylon—now makes its bow in the manufacture of surgical gut. Behind this simple statement go years of planning, research and experimentation.

From *any* angle—strength, smoothness, uniformity of absorption, thoroughness of chromicizing, etc.—you will find Deknatel Surgical Gut the peer of any brand on the market. We invite your inquiries.

J. A. Deknatel & Son, Inc.—manufacturers of surgical sutures and operating room specialties—96-20 222nd St., Queens Village 29, (L.I.) New York.

DEKNATEL *Surgical Gut*

New!

KIMBLE PIPETTES with cotton plug constriction

These new Kimble Pipettes combine Kimble quality with new efficiencies. Their new design prevents the cotton plug from slipping down into the main body.

The constriction is large enough for easy cleaning and in no way weakens the tube; nor does it alter flow characteristics.

You can order these new Kimble Pipettes from your hospital supply house, or write to us direct for a free copy of our latest catalog and price listing.

★
They are legible—
All markings are clearly indicated with Kimble permanent, *fused-in* filler.

★
They are retested—
Each pipette is tested during manufacture, then individually retested for accuracy before shipment.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

from SIMMONS complete line

makes it easier to pick the springs and Bed Ends you want!

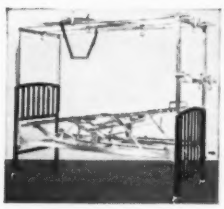
C

HERE ARE A FEW OF THE MANY COMBINATIONS you can make with Simmons interchangeable springs and bed ends. Simmons Springs may be purchased only for Simmons Bed Ends.

H-880-L-171 —7-filler Vari-Rite Bed Ends (H-880), with 3-crank Deckert spring (L-171).*

H-846-L-148 — Modern Semi-Panel Bed Ends (H-846), with improved 2-crank spring (L-148).*

H-800-L-190 — Standard 7-filler Bed Ends (H-800), with Side-Adjusting spring (L-190).*



Bed H-800-3. ALL-PURPOSE BED ENDS—indicated by the suffix (-3) added to the bed number. Have stainless steel baffle bars; built-in sockets for attaching demountable Balkan Frame H-16, Irrigation Rod H-69, and H-16E Shaped Fracture Bar. Have brackets for safety sides.

You'd Expect this of SIMMONS

Simmons, with the aid of down-to-earth suggestions from hospital administrators, doctors and nurses, has been busy working out a flexible system of interchangeable units—springs and bed ends—to help hospitals provide economically the many types of bed service they are expected to supply.

Now you can pick combinations of bed springs and ends which will enable you to provide all bed services with the minimum number of units—for surgery, obstetrics, fracture, convalescent, or special departments such as mental, heart and contagious. Your selection of ends is made easier because most Simmons bed ends are available plain, with brackets for safety sides, or with all-purpose features.

That's not all. You can choose from a wide range of easy-to-clean pastel colors or attractive wood grain finishes when you buy Simmons bed ends. Thus, your rooms and wards can be planned for color harmony as well as maximum service.

Simmons ABC System of Interchangeable Units as outlined here presents the basic idea. But to really understand the wide range of choice and the economy this system provides, see your hospital supply dealer, or visit a Simmons sales room.

SIMMONS COMPANY
HOSPITAL DIVISION

Chicago 54, Merchandise Mart **New York 16, One Park Avenue**
San Francisco 11, 295 Bay Street **Atlanta 1, 353 Jones Ave., N. W.**
Dallas 9, 8600 Harry Hines Blvd..

Another First from EL

Now! A Low-Cost Electric Detergent Control—Fits ANY TYPE Dishwashing Machine!

One For Your Operation

Solu-matic "20"

Dependable . . . Accurate Genuinely Economical!

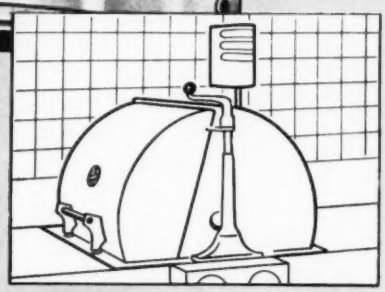
OFFERS YOU THESE BIG ADVANTAGES

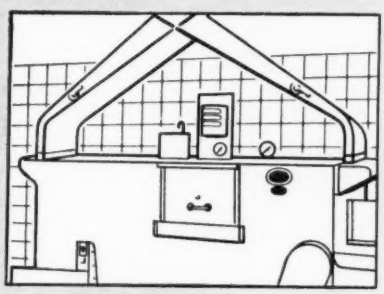
1. **Insures Clean Dishes**
2. **Controls Compound Costs**
3. **Eliminates Guesswork by the Operator**

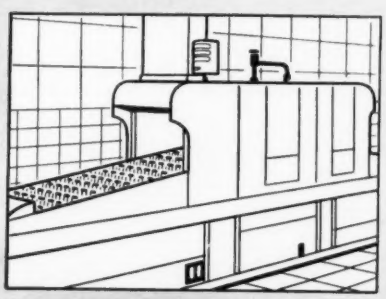
Automatically maintains constant control for hand feeding and automatic feeding. No wasted compound.

Compact simplified design. Completely reliable. Cased in stainless steel.

THE SOLU-MATIC "20" illustrates once again why the operators of America's most efficient dishrooms look to Economics Laboratory for the newest and best developments in cleaning compounds, dispensing equipment—*and service.* The SOLU-MATIC "20" is available from your local SOILAX Representative. Consult your phone book under Cleaning Compounds.







HERE IS HOW THE SOLU-MATIC "20" OPERATES:

Green Light:
Shows compound strength is correct

White Light:
Indicates weakened compound strength

Red Light:
Means compound should be added immediately

EL ECONOMICS LABORATORY, INC., ST. PAUL, MINN.
FACTORIES: CHICAGO, ILL.; LYNDHURST, N. J.; SANTA CLARA, CALIF.

MAKERS OF SOILAX "A" • MIKROKLENE • SUPER SOILAX
SOIL-A-WAY • SOILMASTER • PAN DANDY • GLASS MAGIC
SOILAX "C" • SILVA-DRY • DIP-IT • TETROX • SATINITE

FLORAL THERAPY PAYS DIVIDENDS!

Dividends of happiness to your patients . . . dividends to nurses and doctors, too!

Because cheerful patients are easier to care for. And nothing brightens up a patient like flowers from far-away friends. *That's* Floral Therapy!

And remember, the fresh flowers delivered by your F.T.D. Florist are *pre-arranged* for your convenience. They need no special care.

No extra work or handling with F.T.D. FLOWERS!

TRADEMARK

FLORISTS' TELEGRAPH DELIVERY ASSOCIATION

Headquarters: Detroit, Michigan

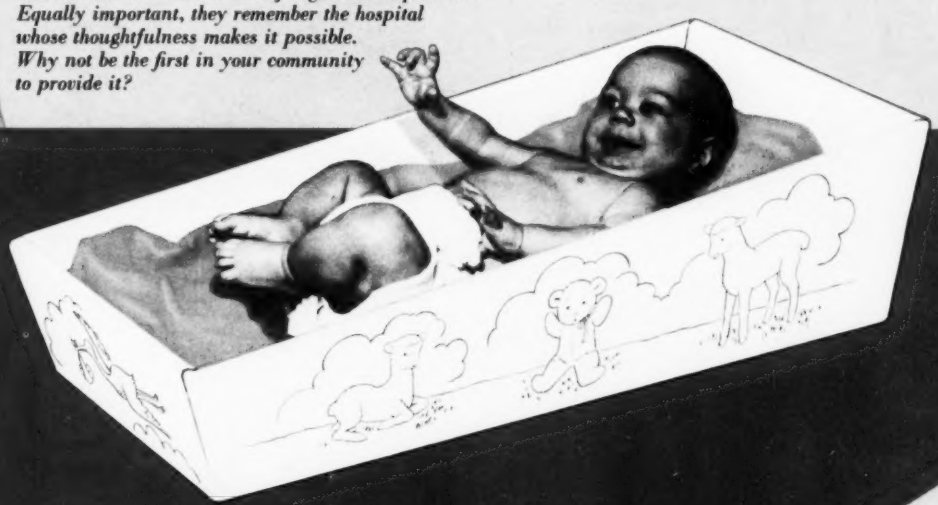
something NEW and Different

for your nursery

the PRESCO DISPOSABLE

BASSINET

The PRESCO DISPOSABLE BASSINET *has a tremendous appeal to parents. They appreciate its utility value and cherish it as a memento of a glorious experience. Equally important, they remember the hospital whose thoughtfulness makes it possible. Why not be the first in your community to provide it?*



HELPS ELIMINATE CROSS-INFECTION...
SAVES TIME AND LABOR...
NO SCRUB-UP OR DISINFECTING...
NO LINERS

Place each new-born infant in his own, individual bassinet. When it's time for the outgoing trip, you'll see extra big smiles as proud parents carry their prodigy home *...still in his own bassinet.*

Nurses' smiles are extra big, too. For there's no bassinet scrub-up and disinfecting. There's no re-use, so there's no work.

Physicians like the DISPOSABLE BASSINET because it helps substantially in eliminating cross-infection.

Hospital Superintendents are quick to see a twofold advantage —the DISPOSABLE BASSINET builds tremendous public goodwill, at the same time provides a substantial source of additional revenue.

Beautiful, practical, and more than pays its way!

- Made of strong, rigid, water-resisting Flute-wood stock. Beautifully coated in white finish.
- Sweet, appealing decorative design in either blue or pink.
- Bassinet is one-piece construction and delivered flat. Can be folded and assembled in one minute. Requires little storage space. Fits any bassinet stand.
- Extremely lightweight yet exceptionally strong. Easily cleaned.
- Parents are delighted to pay for their DISPOSABLE BASSINET. Build goodwill at a worthwhile profit!

Order from any one of these Distributors

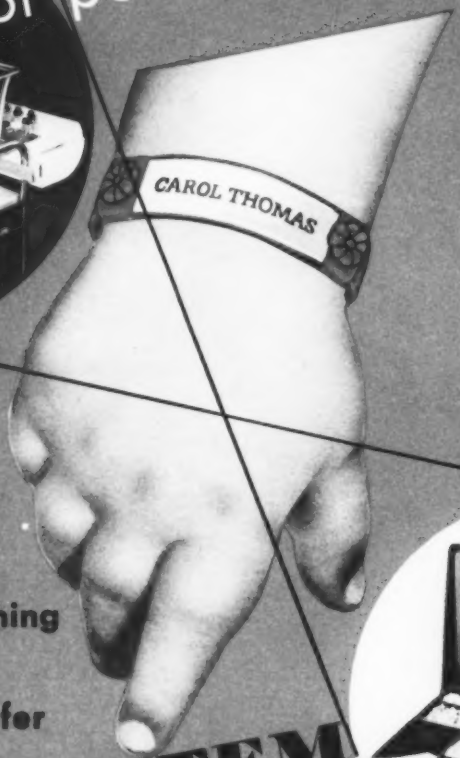
A. S. ALOE COMPANY
1831 Olive St., St. Louis 3, Missouri

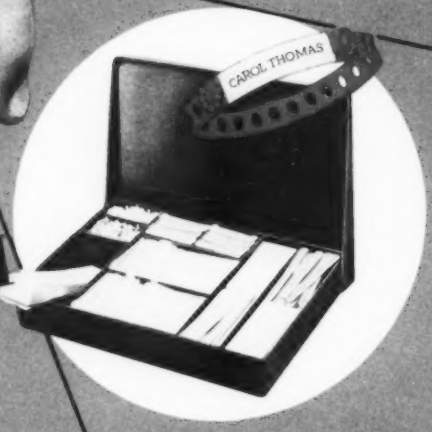
AMERICAN HOSPITAL SUPPLY CORPORATION
2020 Ridge Ave., Evanston, Illinois

MEINECKE & COMPANY, INC.
225 Varick St., New York 14, New York

WILL ROSS, INC.
4285 North Port Washington Road
Milwaukee 12, Wisconsin

for positive identification





it costs you nothing to use this faster, easier, safer

PRESCO SYSTEM

The vast majority of hospitals using the PRESCO IDENTIFICATION SYSTEM are charging one dollar for the bracelet after it has served its protective purpose and becomes a beautiful, priceless keepsake. Even at the minimum charge of fifty cents, each bracelet more than pays its own way.

The PRESCO system is simplicity itself. A soft, pliable plastic bracelet (*non-toxic to skin*) is slipped around wrist or ankle. It does not have to fit tightly, yet stays comfortably and safely in place. On in a jiffy, with a minimum of preparation. And it won't come off until it is cut off.

The name card (which is slipped and automatically locked into the transparent bracelet) provides ample space on the back for additional data and fingerprint, if desired.

for ***free samples*** *and the complete story, write the PRESCO COMPANY, INC., Hendersonville, N.C.*

PRESCO BABY KIT
contains 144 complete bracelets (72 blue and 72 pink) **$39.75**
(*Adult size packed all pink, all blue, or all white; same price*)

PRESCO REFILLS
144 complete bracelets, (72 blue and 72 pink,) **$43.20**
(*Adult size packed all pink, all blue, or all white; same price*)

Adult Size Bracelets
are especially recommended for use in surgical cases and in multiple-bed rooms. They're a never-failing "double-check" in the cause of complete accuracy.

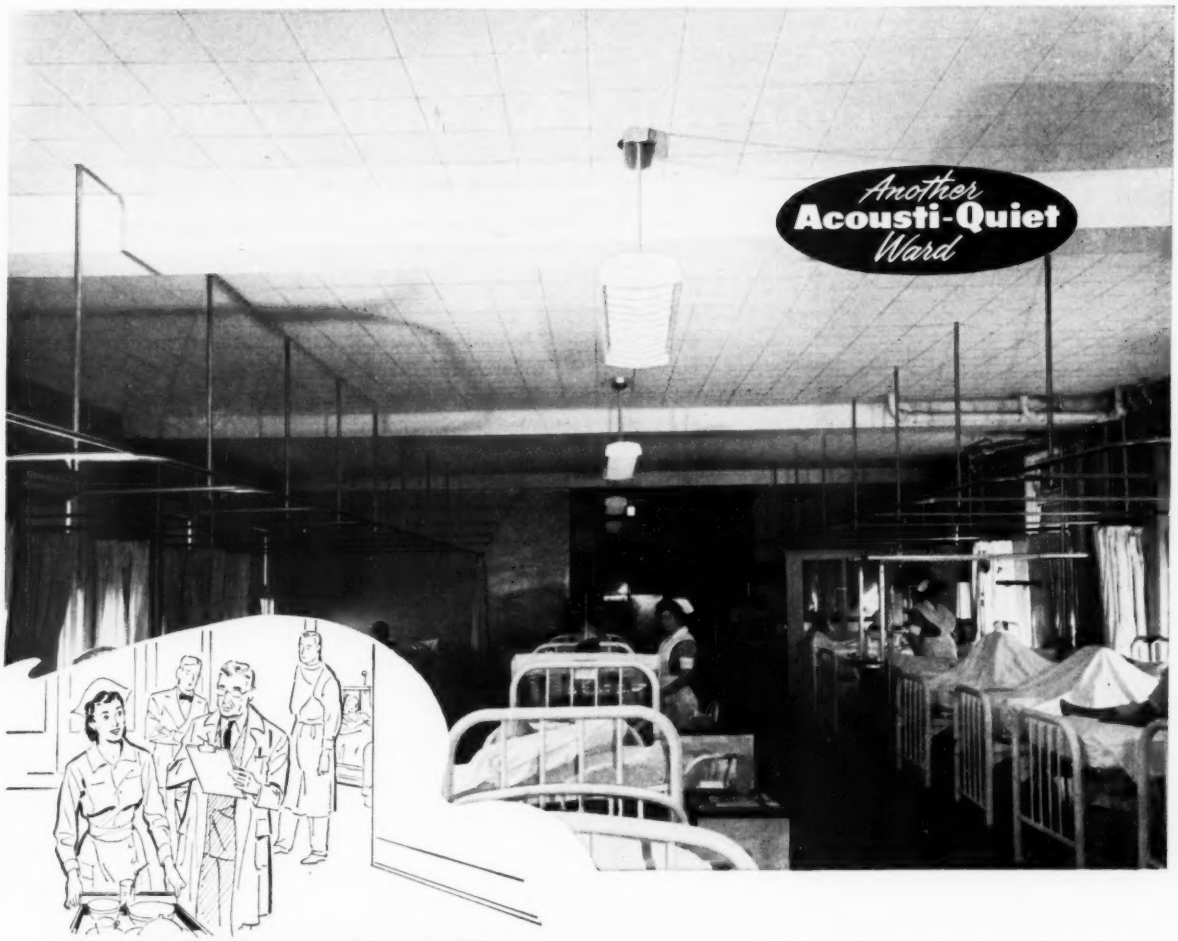
Order from any one of these Distributors

A. S. ALOE COMPANY
1831 Olive St., St. Louis 3, Missouri

AMERICAN HOSPITAL SUPPLY CORPORATION
2020 Ridge Ave., Evanston, Illinois

MEINECKE & COMPANY, INC.
225 Varick St., New York 14, New York

WILL ROSS, INC.
4285 North Port Washington Road
Milwaukee 12, Wisconsin



QUIET, PLEASE...people "on the mend"!

Cases vary and treatments differ, but there's one thing *all* hospital patients have in common—they need *rest and quiet!* Yet, in many otherwise fine hospitals, this simple prescription is not filled. Patients are denied the soothing, healing benefits of quiet comfort because the unavoidable noise of daily hospital tasks is *needlessly permitted to go unchecked!*

Low-Cost Answer

The economical solution to this problem, hundreds of hospitals have found, is Acousti-Celotex Sound Conditioning. A sound-absorbing ceiling of Acousti-Celotex Tile checks irritating, disturbing noise in wards, nurseries, operating and delivery rooms, corridors, lobbies, kitchens, utility rooms. It brings restful quiet that aids convalescence and also improves the working efficiency of hospital personnel.

DOUBLE-DENSITY—As the diagram shows, Acousti-Celotex Tile has two densities. *High density* face, for a more attractive finish of superior washability, easy paintability. *Low density* through remainder of tile, for controlled sound-absorption value.

Easy Maintenance

Acousti-Celotex Tile is quickly installed, requires no special maintenance. Its unique *double-density* feature (see diagram) provides excellent sound-absorption value plus a surface of remarkable beauty and washability. Can be washed *repeatedly* and painted *repeatedly* with no loss of sound-absorbing efficiency.

MAIL COUPON TODAY for a Sound Conditioning Survey Chart that will bring you a *free analysis* of your particular noise problem plus a factual free booklet, "The Quiet Hospital." No obligation.

ACOUSTI-CELOTEX

TRADE MARK REGISTERED U. S. PAT. OFF.

Sound Conditioning

Products for Every Sound Conditioning Problem—The Celotex Corporation, 120 S. La Salle St. Chicago 3, Illinois • In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec

Mail Today

The Celotex Corporation, Dept. G-24
120 S. La Salle St., Chicago 3, Illinois

Without cost or obligation, send me the Acousti-Celotex Sound Conditioning Survey Chart, and your booklet, "The Quiet Hospital."

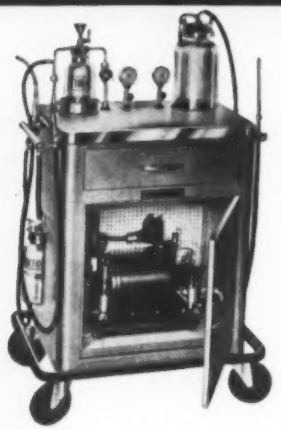
Name_____ Title_____

Address_____

City_____ County_____ State_____

IMPROVED

. . . SKLAR-BUILT SUCTION AND PRESSURE UNITS

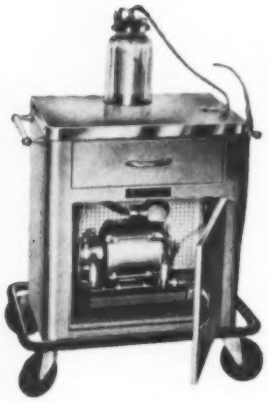


* ***Improved motor assembly and simplified electrical installation result in lower manufacturing costs which are reflected favorably in the prices of these new models.***

These suction and anesthesia units are totally explosion proof and approved by Underwriters' Laboratories, Inc. for use in Class 1, Group C hazardous locations. All tubing, casters and bumpers on the Bellevue and Printz models are of conductive rubber. Motor units are rubber mounted, minimizing vibration. Cabinets are insulated with Celotex to insure noiseless operation.

NEW IMPROVED BELLEVUE MODEL, CAT. No. 100-75.

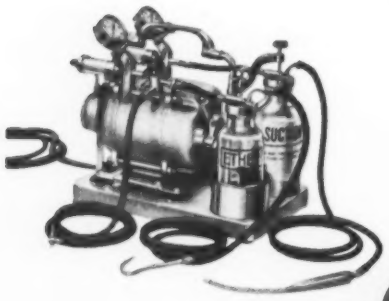
Now equipped with 32-ounce suction bottle for the exclusive use of the anesthetist in addition to the regular 1-gallon suction bottle and 32-ounce ether bottle.



NEW IMPROVED PRINTZ MODEL SUCTION UNIT, CAT. No. 100-80.

Equipped with 1-gallon suction bottle and recessed suction gauge. *Printz* Model, Cat. No. 100-85 (not illustrated) has a 32-ounce ether bottle in addition to the 1-gallon suction bottle.

Printz Model, Cat. No. 100-87 (not illustrated) is same as 100-85 but equipped with separate rotary compressors for ether bottle and suction bottle.



NEW IMPROVED TOMPKINS MODEL SUCTION AND ANESTHESIA UNIT, CAT. No. 100-10.

Complete with 32-ounce suction bottle, 16-ounce ether bottle, two-way by-pass valve and spray tube. Sklar Pump Table, Cat. No. 100-40 (not illustrated) mounted on conductive rubber casters, complete with utility drawer, shelf and rack for sprays and sinus cleanser. Tompkins Model for suction only, Cat. No. 100-15 (not illustrated) is equipped with two 32-ounce suction bottles and no ether bottle.

Standard color for all units is Sklar silver grey baked enamel.

DESCRIPTIVE LITERATURE ON REQUEST

SKLAR PRODUCTS

UL

Sklar

LONG ISLAND CITY, N. Y.

Sklar Equipment is available through accredited surgical supply distributors.

They all like

pediatric

ERYTHROCIN

TRADE MARK

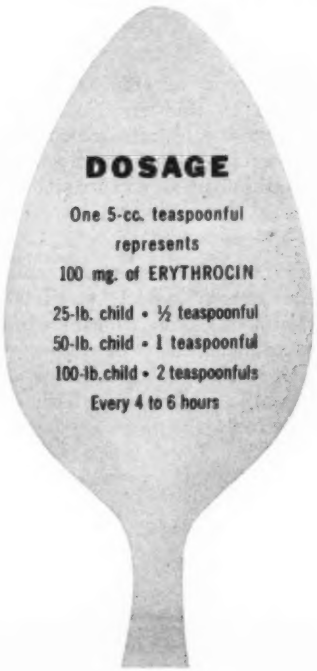
STEARATE

(Erythromycin Stearate, Abbott)

oral suspension

. . . the cocci-killing antibiotic for children of all ages. Tasty, stable, ready for instant use. *No mixing required*—drug retains potency for at least 18 months.

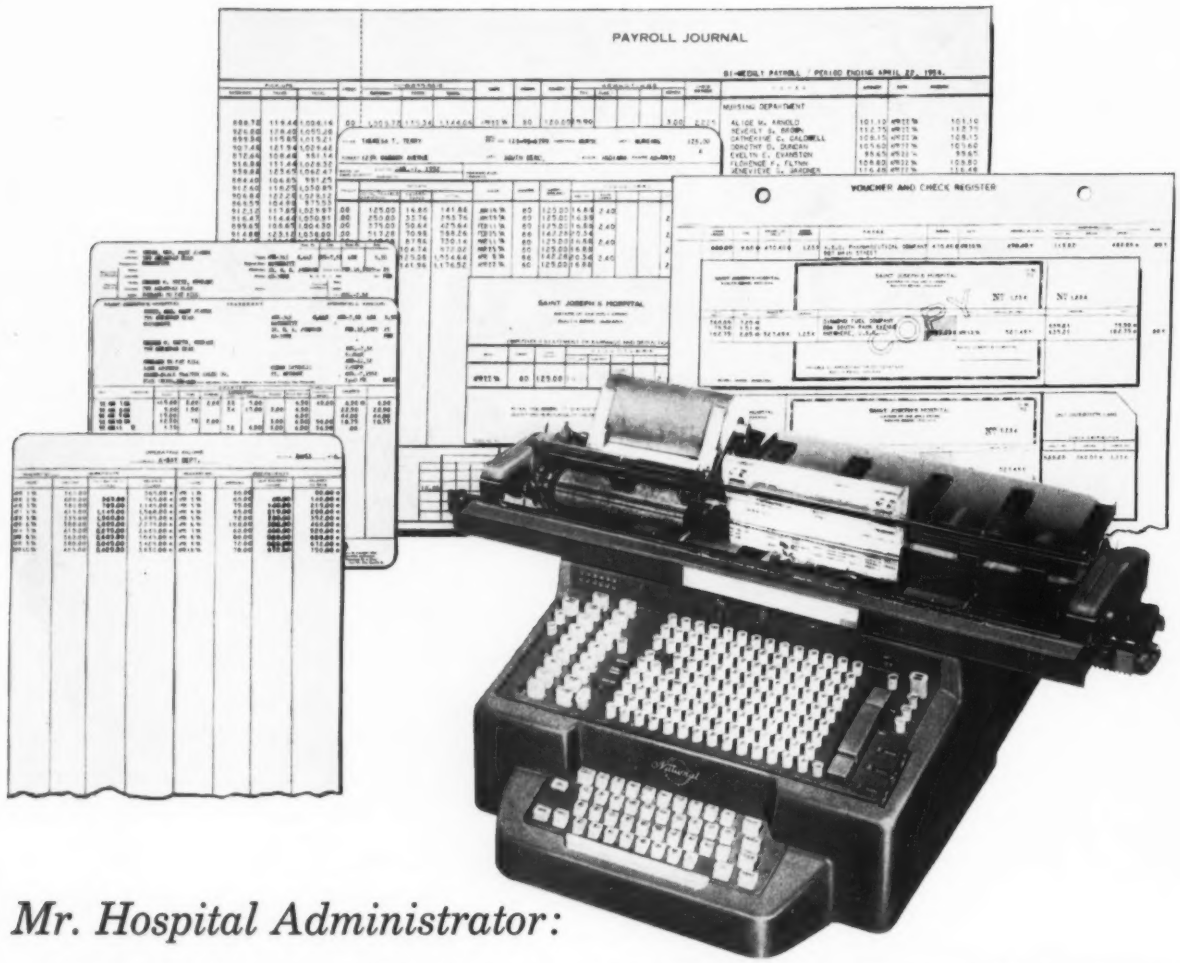
Winter infections—otitis media, bronchitis, sinusitis, pharyngitis and pneumonia—are especially sensitive to *Pediatric* ERYTHROCIN. Also, pyoderma, erysipelas, certain cases of osteomyelitis, and other infectious conditions.



Many physicians make it a practice to always prescribe *Pediatric* ERYTHROCIN when the organism is staphylococcus, because of the high incidence of staphylococcic resistance to many other antibiotics. And when the organism is resistant or when the patient is sensitive to penicillin and other antibiotics.

Pediatric ERYTHROCIN is specific in action—*less likely to alter normal intestinal flora than most other antibiotics.* Gastrointestinal disturbances are rare. No serious side effects reported.

Pediatric ERYTHROCIN can be administered before, after or with meals. Available in 2-fluidounce, pour-lip bottles.
Your little patients will like *Pediatric* ERYTHROCIN. Abbott



Mr. Hospital Administrator:

You can reduce your Accounting Costs!

The National Class 31, especially adapted for hospital work, is a "Multiple-Duty" machine. This versatile machine can do *all of your accounting work*, limited only by the time required to post your total volume.

How can hospital posting work be accomplished on one machine? Simply by changing—in a matter of seconds—removable posting bars, which are specially constructed to provide maximum posting efficiency on forms that best meet your requirements.

How can this reduce your accounting costs? Only NATIONAL, which developed this Class 31 especially for hospital applications, combines on one machine those FOUR ESSENTIAL FEATURES which permit all records to be posted in the most *time-and-money-saving manner:*

1. **Electric typewriter**
2. **Full flexible amount keyboard**
3. **Full visibility of posting**
4. **Rapid-change removable posting bar . . . that changes the machine for a different job in just a few seconds.**

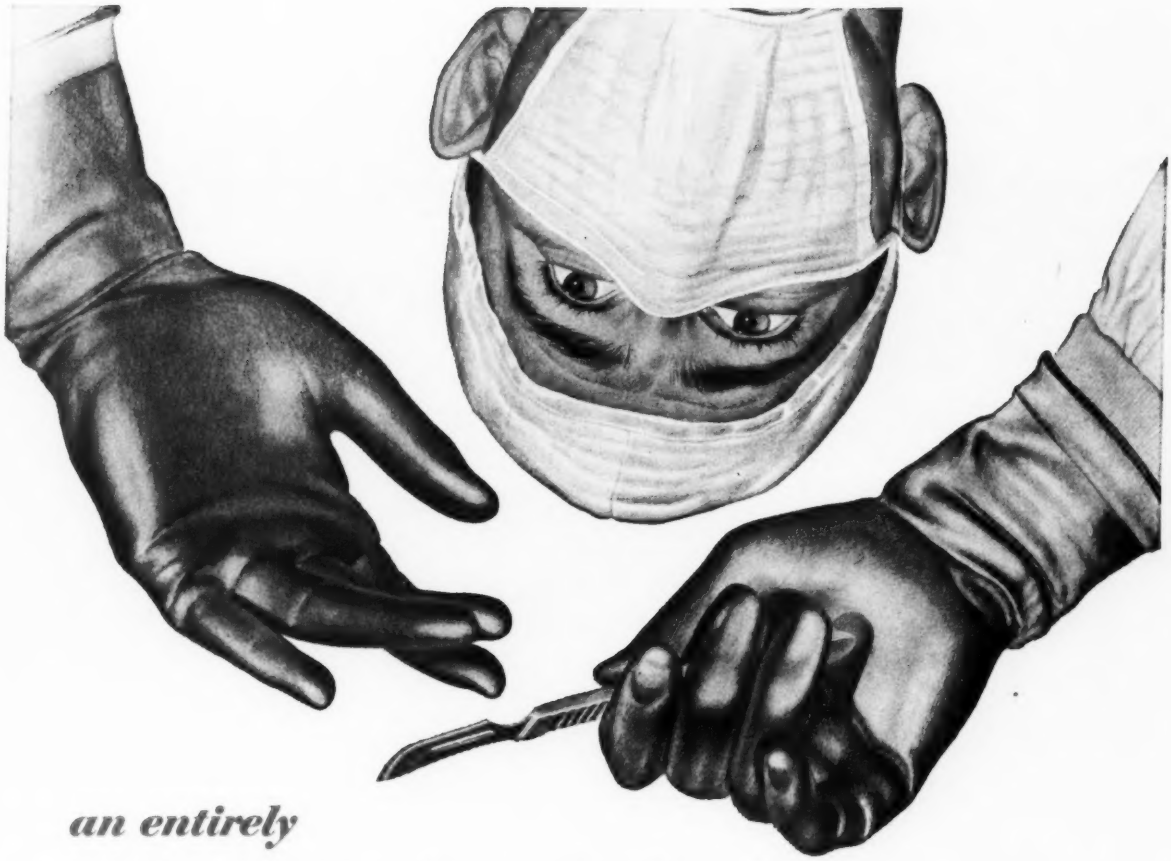
Its new fluid-drive carriage gives smoother, faster operation. Automatic selection and control of more than 70 machine functions permits the operator to accomplish more work in less time—with less effort. On some jobs the machine does 2/3 of the work automatically . . . and what the machine does automatically, the operator cannot do wrong.

When all your accounting records are posted by this new NATIONAL, complete and accurate accounting information is always instantly available. Thus informed, you are enabled to manage your hospital *more efficiently* and *more profitably.*

Ask your local National representative—a systems analyst—to explain how *National's Class 31* can reduce your accounting costs. Let him show you why so many hospitals now use this versatile machine as a basic accounting tool.

National
ACCOUNTING MACHINES
CASH REGISTERS • ADDING MACHINES

THE NATIONAL CASH REGISTER COMPANY, Dayton 9, Ohio



an entirely

different view on antisepsis

Bactericidal, yes! But that's not all that makes Zephiran chloride an outstanding antiseptic.

The power to penetrate crevices and folds...to spread to contaminated surfaces...to act rapidly on a wide variety of micro-organisms...characterizes the germicidal qualities of this antiseptic.

Zephiran chloride, as a cationic detergent, has marked wetting and penetrating activity because it reduces surface tension. Its dispersive power is a valuable adjunct to gram-negative and gram-positive bactericidal potency.

Supplied as Aqueous Solution 1:1000, bottles of 8 oz. and 1 U.S. gallon. Tincture 1:1000, tinted and stainless, bottles of 8 oz. and 1 U.S. gallon. Concentrated Aqueous Solution 12.8%, bottles of 4 oz. and 1 U.S. gallon (1 oz. = 1 U.S. gallon 1:1000 solution), must be diluted.

for antisepsis with finesse

ZEPHIRAN® chloride

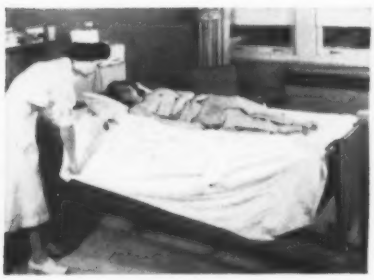
Zephiran, trademark reg. U.S. & Canada, brand of benzalkonium chloride (refined)

Winthrop-Stearns Inc.
New York 18, N. Y.—Windsor, Ont.

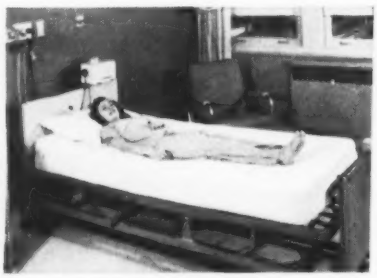
WINTHROP

A Case History of Pacific *in the* Waukesha

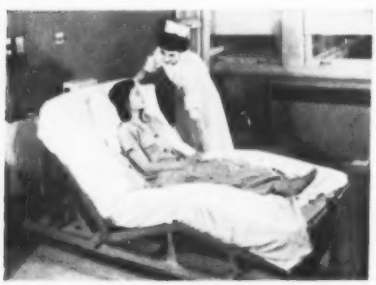
6¢ per patient per day saved by these mattress-fitting sheets



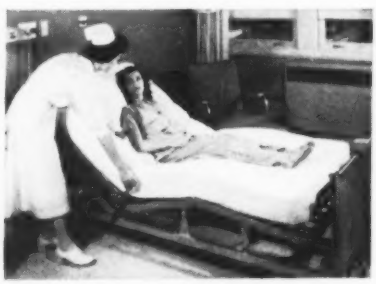
With flat bottom sheets that rumpled, it was routine for the nurse to smooth bed on the average of four times a day.



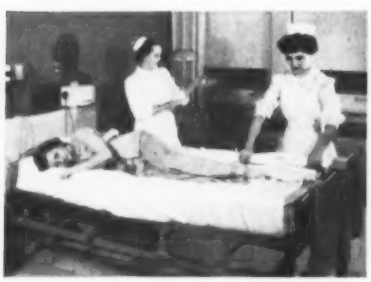
Pacific Contour Bottom sheets stay smooth . . . have eliminated all complaints regarding sheet adjustment.



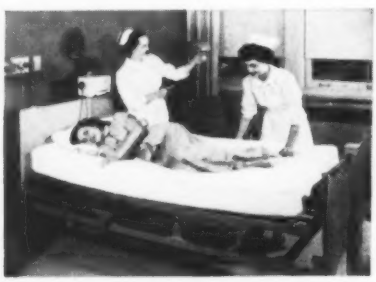
Flat bottom sheets pulled out . . . upon elevation of gatch bed.



Pacific Contour stays firmly tucked in . . . no matter what position the mattress.



Flat bottom sheets required daily changing because of muss. Tests show, with patient in bed, changing bottom sheet and draw sheet takes 110 seconds.



Neatness of Pacific Contours eliminates daily changing. Leaving bottom sheet on bed, changing draw sheet only, takes 45 seconds . . . saves 65 seconds per bed.

® "Contour" is the registered trademark for Pacific's fitted sheets.

IN JUNE 1950, the Waukesha Memorial—one of Wisconsin's model hospitals—began the experimental use of Pacific Contours® in its 30 bed obstetrical department.

In use, these *mattress-fitting* sheets proved to be an asset in patient care and a definite economy as well. Their benefits were so substantial that in August 1951 (just 14 months later) Waukesha Memorial converted *every adult* bed in the hospital to Pacific Contours. (Both 36″ x 75″ and 36″ x 80″ size mattresses.)

Here are some of the reasons this hospital moved so swiftly to revolutionize its bedmaking.

"Patients have comfort all of the time with Pacific Contours," the Waukesha Memorial states. Nurses report these mattress-fitting sheets never wrinkle or bunch-up beneath the patient. It is unnecessary to adjust the Pacific Contour during the entire time it remains on the mattress. Formerly they had to adjust flat bottom sheets approximately four times a day.

Nurses find Pacific Contours ideally suited to the hospital's gatch beds. When the bed is elevated, this snug-fitting bottom sheet does not pull out or slip downward—thus keeping the draw sheet and top sheet more securely in place.

And where plastic mattress covers are used, the problem of sheets sliding off is solved. Four boxed corners and a deep tuck-under hold the Pacific Contour firmly in place. It unites four separate units—the mattress, the pad, mattress cover and sheet—into one unit.

"The Pacific Contour is particularly beneficial for orthopedic cases in traction." Weights and pulleys make it extremely difficult to move such cases—hence changing the bed with standard flat sheets has always been a laborious job. Nurses find the Pacific Contour Bottom sheet much easier to apply. There is less need to disturb the patient, because the boxed corners slip over the mattress and the sheet centers itself on the bed.

"Saves vital hours of nursing personnel time." Time-tests conducted at

Contour Sheets Memorial Hospital

***Four boxed corners and deep tuck-under** hold the Pacific Contour sheet snug and wrinkle-free. Sturdily tape-reinforced, the corners in the Pacific Contour are the longest wearing type made.*

***"We change Pacific Contours only every five days,** in usual cases," the Housekeeping Department reports.*

Waukesha Memorial prove—changing the bottom sheet and draw sheet *with patient in bed* is almost two times faster with Pacific Contour Bottom sheets than with flat sheets. (When housekeeping department makes up empty bed, Pacific Contours are *over 3 times faster* to apply than flat sheets.)

Even more important, the hospital finds Pacific Contours require changing far less often than flat sheets that muss. With a bottom sheet that can remain on the mattress for several days, the nurse's bedmaking work is speeded up greatly.

"Pacific Contours stay cleaner longer—we get more days of patient use per sheet." This smooth-fitting sheet collects less soil than sheets that wrinkle. Food crumbs, cigarette ashes and other casual soil can easily be brushed off its smooth surface without leaving stains.

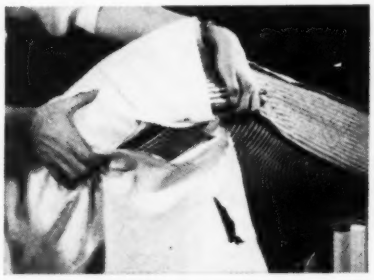
At Waukesha Memorial, the Pacific Contour Bottom sheet *is normally changed only every five days.*

"Pacifics have far longer use life . . . reduce replacement costs." The less frequent washing of Pacific Contours means less wear and tear. Waukesha Memorial estimates that after 200 washings, 50% of a sheet's value is gone . . . and the sheet is torn up for rags. The Pacific Contour Bottom sheet, laundered much less often than flat sheets, stays in service many times longer. The housekeeping department reports that since the hospital adopted Pacific Contours in 1950, only two had to be replaced. Neither of these sheets had worn out; one was discarded because of a burn, the other because of a medicine stain.

"We tumble-dry Pacific Contours . . ." The snug-fitting Contour Bottom sheet *smooths itself* on the mattress. No ironing is necessary. Another economy for the hospital—Pacific Contours weigh less than conventional sheets . . . cut washing costs.

"Pacific Contours need less mending." The repair shop of Waukesha Memorial reports they mend an average of 40 flat sheets a month—compared to *three Pacific Contour sheets a month.* Their explanation of this longer wear: nurses and patients do not need to smooth and pull on these mattress-fitting sheets. Also—unlike flat sheets—the fitted tuck-under of Pacific Contours leaves no excess sheet to catch on a bedspring and tear.

"We estimate that the total savings in using Pacific Contour Bottom sheets exceed 6¢ per patient per day," the administration of Waukesha Memorial states. "After one year of use throughout the hospital, we would not consider reverting to ordinary bottom sheets."



***Flat sheets can catch on bedsprings . . .** rip, tear. Waukesha Memorial mends average of 40 flat sheets a month.*

***Fitted tuck-under of Pacific Contours** eliminates this hazard. Only 3 Pacific Contours a month repaired.*

* * *

The case history above is just one example of how modern institutions are converting to these sheets that are so popular in American homes. Approximately 15 million Pacific Contours are in home use today.

Consider what the economies made possible by Pacific Contours would mean in terms of your hospital. The *surprising fact is these mattress-fitting sheets are priced as low as flat sheets.*

Pacific Contours are available in white Extra-Strength muslin in four hospital sizes:

27″ x 52″ (Crib Size)	36″ x 77″
36″ x 75″	36″ x 80″

A color marking distinguishes each size for easy identification. All Sanforized®.

Send in coupon for following reports: 1) Waukesha Time Study. 2) The York Research Corporation study showing time saved by Pacific Contours in bedmaking of hotel maids. 3) The American Institute of Laundering bulletin on new methods that reduce costs of laundering Pacific Contours to only a fraction of a penny more than flat sheets.

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Modern hospitals aid patient recovery with a thermostat in every room

The separate thermostat in the Hydrotherapy Room provides higher temperatures so the patient can relax without chilling, and react better to treatment.

Carefully controlled temperatures stimulate orthopedic activity in the High School classroom of the hospital . . . students now study in a pleasant, comfortable environment.

TEMPERATURE CONTROL *in every room* allows more freedom of treatment and speeds patient recovery in the Mary Free Bed Guild Hospital and Orthopedic Center in Grand Rapids, Michigan. Pleased authorities there noted the easy installation of Honeywell thermostats in every room *without tearing up floors, removing pipes or radiators.*

Before this modernization, some rooms received too much heat, and others too little, depending on the season. But Honeywell Individual Room Temperature Control corrects this problem—and gives the added advantage of warmer temperatures for *special treatment rooms* without affecting other units or wasting costly fuel.

The Mary Free Bed Hospital, dedicated to the care and education of crippled and afflicted children since 1891, recognized the real need for individual room thermostats and acted on this worthwhile modernization. Do you have all the facts for modernizing *your* hospital with Honeywell Controls? If not, call your local Honeywell office . . . or write Honeywell, Dept. MH-2-13, 351 East Ohio Street, Chicago 11, Illinois.

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You get *all* these features *only* in this specially designed Honeywell Hospital Thermostat:

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104 offices across the nation

Bolta-Wall installation at Seton Hospital, Austin, Texas, shows handsome Leathergrain Pattern on corridor walls. Bolta-Wall was chosen for use throughout this hospital for its ability to resist stains, scuffs and scratches while retaining its fresh beauty.

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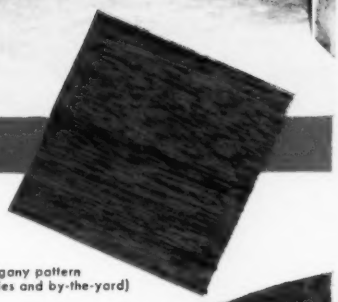
NEW, VINYL

Bolta-Wall

by the tile and by the yard



Mahogany pattern
(in 8" x 8" tiles and by-the-yard)

Leathergrain pattern
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Bolta-Wall is remarkably durable and unusually handsome. Ideal for "rough-treatment" areas and for the most luxurious public rooms, Bolta-Wall gives long-lasting beauty to *all* walls.

Maintenance costs are low because Bolta-Wall needs no repairs, no replacement under normal usage. Bolta-Wall resists fats, oils, grease, alcohol, detergents. Most stains can be wiped away with a damp cloth. It has marked resistance to scuffs and scratches, is fire-retardant* and dimensionally stable.

The quality and durability are unique at the price. *You can get nothing comparable without paying up to 30% more.* Distinctive Bamboo, Leathergrain and Woodgrain patterns provide years of beautiful wall protection in homes, hospitals, hotels, schools, restaurants, theaters, offices.

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Temperature

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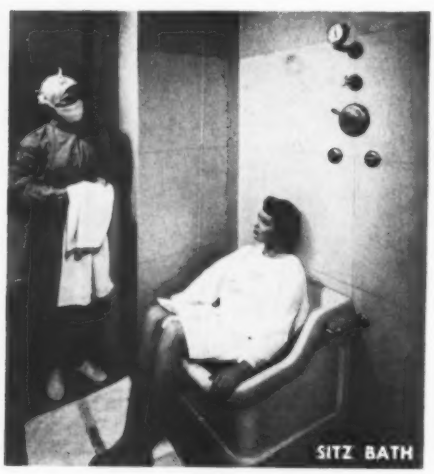
One of Three Modern Air Conditioned Operating Rooms pneumatically controlled by Powers Thermostats and Hygrostats. Photo above shows modern Thoracic type operating table. X-Ray Room and Research Lab, (at right) and other spaces thruout this modern nine story building also are Powers controlled.



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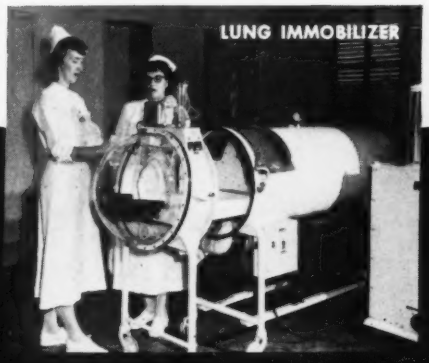
Throughout This Modern TB Sanitarium is POWERS Controlled



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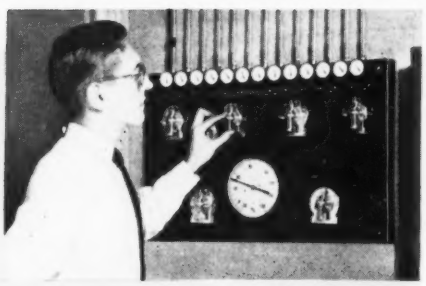

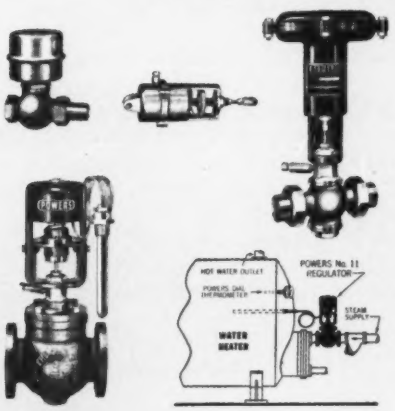

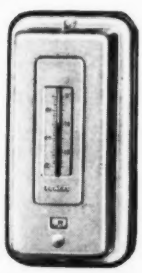

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(b49)

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Nursing education groups and instructors have long recognized the importance of utilizing films and other visual materials in the teaching of the professional nurse.

To assist with this method and concept of instruction, Johnson & Johnson has made available a variety of unusual teaching aids. Included is a "Sourcebook of Visual Materials for Nursing Education" which catalogs and describes certain films and teaching media which are available on free loan.

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Johnson & Johnson

Small Hospital Questions

Employe Wants to Know

Question: What in general does the employe want in communications that he might receive from management, *i.e.* is he primarily interested in information on work conditions, business trends affecting his office operations, personnel news, what?—S.C., Ill.

ANSWER: What the employe wants and what the employer wishes he'd want are, of necessity, rather different things. The employer thinks of his various methods of communication as aids in promoting greater productivity through better understanding of the employer's problems and realization of the importance of the individual on his own job. He wants to get away from the "I just work here" attitude and to stimulate a feeling of loyalty in the employe to his job and to his employer and to instill the conviction that he is a good employer to work for.

Much of the communications effort, no matter what medium is used, is in this sense employer propaganda, which he hopes will have some bearing on the positive approach to these needs of his own. The employe often responds to skillful treatment of this subject because, after all, all of us have our own sense of pride that makes us respond to the appeal of anyone who indicates that our opinion is important enough for him to try to influence it. To the degree that this approach brings about a greater sense of participation in a joint enterprise, it can be useful. To say, however, that it is what the employe *wants* is something else again.

We believe that the average employe would really like to know and be kept informed about the following points:

1. Anything that affects his job security is extremely important. The general condition of the business is something he is interested in.

2. He wants to know, and right now, the reasons behind any change that affects his own personal working conditions. These changes might relate to changes in company structure, product, financial status, mechanical development, or any one of a number of things. And if these changes are going to make any difference in how he does things and under what surroundings and circumstances, he wants to know why.

3. He wants to be kept informed as to his opportunities for personal advancement—whether or not he is in a dead-end job, or whether he has a chance, if he deserves and earns it, to move on up.

4. Next, and not quite so consciously, he wants the feeling of being useful. Most employes appreciate information that relates their specific job to the enterprise of which they are a part.

5. Then, he wants to know the employer attitudes on issues that are of importance to him. For example: If a union is engaged in an organizing drive, the average employe, while he may not admit it, is much interested in how his employer is looking at the matter.

6. Generally, in relation to all these things and everything else, he wants to be able to get at the facts of any matter that interests him in areas where rumors tend to spread.

7. Finally, and almost overshadowing everything else, the employe wants to know the conditions on which the employer bases his schedules of pay and other benefits, as compared with others to whom he compares himself. Most people looking at their own status are inclined to be satisfied with it. If, however, they look at that of another individual with whom they are in a position to compare themselves as being either equal, more important, or less important, and find what seems to be discrepancies in the employer's evaluation as indicated by the compensation factor, they can get unhappy in a hurry. This means that, whether or not a union is in the picture, an employer should be very sure that his employes understand the principles of his position classification and salary administration programs in order that they may apply these fairly in making judgment on these matters of internal comparison.—DONALD E. DICKASON, *director of nonacademic personnel, University of Illinois.*

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala., William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Drug Ordering Policy

Question: In our 60 bed hospital we have our own pharmacy and a part-time pharmacist. However, we do not have a pharmacy committee of the staff, and we commonly order whatever drugs our staff doctors specify. Is this practice in line with what other hospitals in our group are doing? — M.P., N.Y.

ANSWER: Yes, but practice is changing toward the systemization of pharmaceutical purchasing and inventory practice in the smaller hospitals, as these figures taken from recent surveys indicate: In a 1950 survey, only 20 per cent of hospitals in the 50-100 bed class had staff pharmacy committees; in 1952, 40 per cent of hospitals in this group had pharmacy committees. In the 1950 survey, 80 per cent of 50-100 bed hospitals were stocking whatever drugs were specified by attending staff members; in 1952, 74 per cent of these hospitals stocked any drug ordered by a staff doctor. In both surveys, 20 per cent of the hospitals reported they employed a full-time pharmacist.

Does Signing Notes Help?

Question: Do many hospitals ask patients or their families to sign notes for uncollected accounts? Is this an effective way of improving collection experience?—B.T., Ky.

ANSWER: This method is used by some hospitals but has not been widely adopted in the medical field, probably because of the feeling that patients and their families will resent the request to sign notes, and hospital public relations will suffer. Hospitals that have used the method report such fears are unfounded, provided arrangements are handled tactfully, and that "note accounts are much easier to collect than ordinary accounts."

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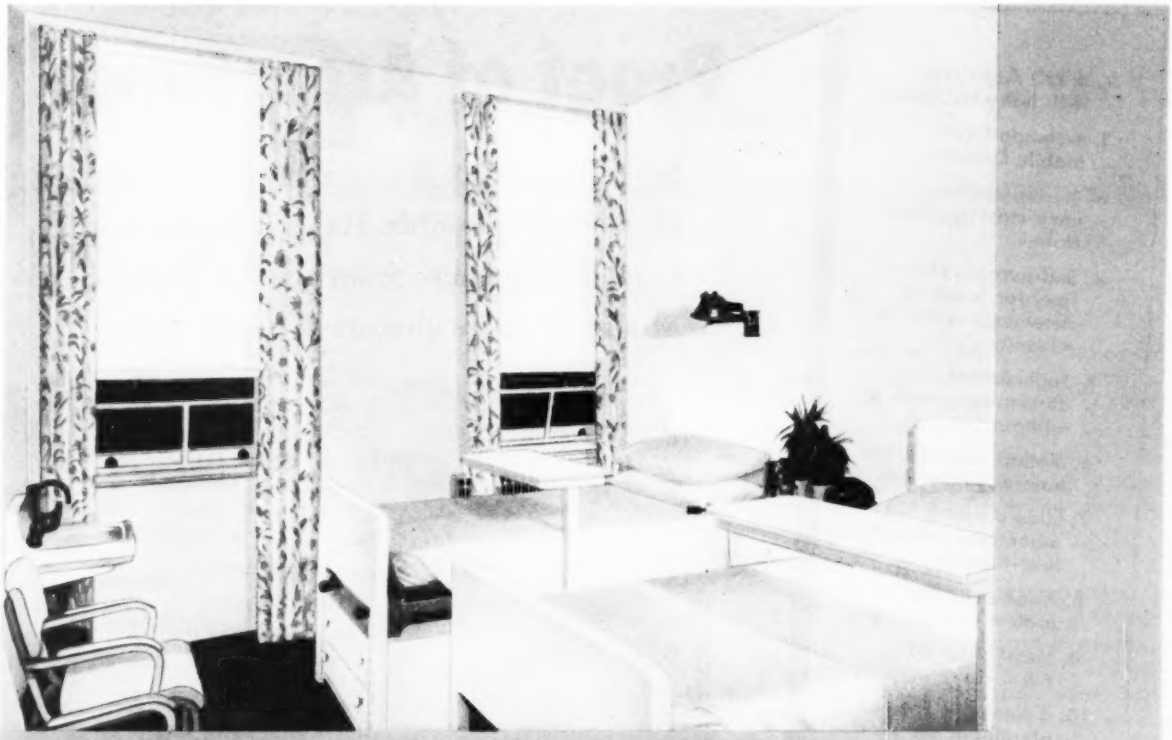

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3. Increases efficiency of nursing staffs
4. Reduces housekeeping problems

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By the use of COLOR DYNAMICS, your patient rooms can be given color arrangements that assist convalescence. Similar purposeful use of color in operating rooms helps relieve eye fatigue and nervous tension among surgeons. Proper colors at nurses' stations will improve alertness and efficiency. Waiting rooms can be made more cheerful and inviting.

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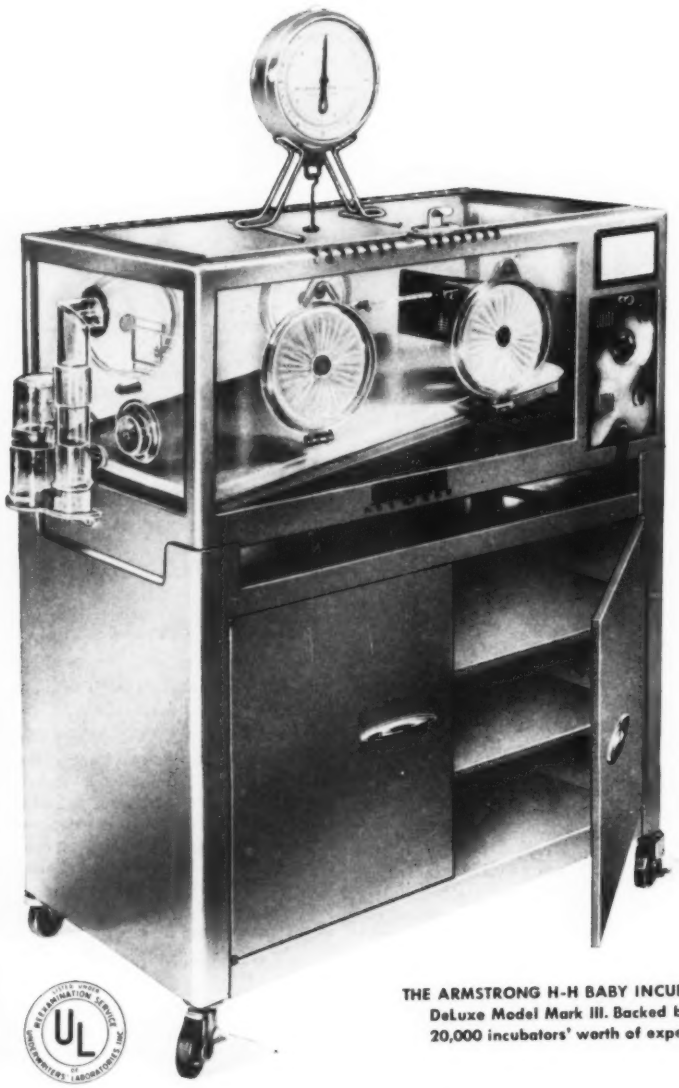

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PRESIDENT'S PROGRAM

While Congress generally appears not to share the Administration's feeling of urgency, the lawmakers are off to a fast start on at least one subject that could prove important to hospitals. Only a month after House and Senate reassembled, the House interstate and foreign commerce committee had about concluded its public hearings on voluntary health insurance problems.

This isn't assurance that legislation to shore up health plans will be adopted this session. But it is reasonable evidence that there will be time to pass a bill if Congress wants one passed.

Although the House hearings are not directed at any one piece of legislation, the idea of a federal corporation to underwrite or "reinsure" voluntary health insurance plans has received a great deal of attention. It has two strategic advantages over other suggestions before the committee: (1) The reinsurance idea carries the copyright of Committee Chairman Charles A. Wolverton, who first introduced a bill on this subject almost four years ago. (2) This idea was singled out by President Eisenhower as most feasible of adoption at this time. The President first suggested reinsurance in his State of the Union message early in the session. Subsequently he spelled out what the Administration wants in his special message on health.

In brief, the federal government would set up and provide original capital for a corporation to underwrite any voluntary health plans willing to abide by the regulations. The federal corporation would pay "catastrophic" illness hospital and medical costs in excess of a stated amount. Participating plans would be required to scale down their premiums so the lowest income group could afford to carry hospital, medical care and surgical insurance.

At this point there is a great deal of uncertainty as to what the House committee will put into the bill if it finally reports one out. In fact, only about three points are certain—federal impetus, the opportunity for catastrophic coverage, and the requirement that all participating plans cut down their premiums for poor families.

President Eisenhower used the term "private," which the commercial companies use to describe themselves. He definitely wants to have them included. On the other hand, Mr. Wolverton's bill limits participation to nonprofit groups.

The Wolverton idea is for an original $50,000,000 federal grant to start the reinsurance in motion, and subsequent federal grants to make up deficits. **In his special message on** health, President Eisenhower proposed only $25,000,000. However, there is a feeling among some of the insurance authorities that the plans eventually could support a reinsurance corporation of their own, with no strings attached to Washington. They think that in a very few years the original financial assistance also could be repaid.

There is complete confusion, too, as to the regulations to be required, setting standards for such things as percentage of outstate subscribers, limit on over-the-schedule payments to hospitals and physicians, length of hospital stay, and participating payments by patients. With regular federal help, the estimate is that the plans would have to contribute no more than 2 per cent of their gross premiums to the federal reinsurance corporation; if the plans want to go it alone, the rate is estimated at 3 per cent.

At the House hearings, a parade of witnesses told Mr. Wolverton's committee of their experiences with health plans, and what they thought the federal government should do to help. Included were Henry J. Kaiser; Dr. Paul B. Magnuson, who said the 1952 commission which he headed liked the reinsurance idea (but did not recommend it); Dr. George Baehr of New York's H.I.P.; Fred Umhey speaking for the International Ladies Garment Workers, A. J. Hayes for the Machinists, Nelson Cruikshank for the A.F. of L. and Walter Reuther for C.I.O.; Jerry Voorhis of the Cooperative Health Federation; Dillon S. Meyer of Group Health; Dr. Dean A. Clark of Massachusetts General Hospital, and Lowell J. Reed of Johns Hopkins; George Bugbee of A.H.A., and E. A. vanSteenwyk of Blue Cross and Blue Shield. A few management representatives appeared, as did witnesses for the American Medical Association.

HILL-BURTON GETS A BOOST

The House committee is expected shortly to turn its attention toward another suggestion for bringing more and better medical care to more people at a minimum cost. It is legislation to alter the Hill-Burton law so grants can be given for construction of diagnostic and rehabilitation facilities and nursing homes.

One of the surprises in the Administration's health program was the high priority given the plan for broadening the H-B program. In his State of the Union message, Mr.

For further details of the President's program, see Page 72

Eisenhower left no doubt of what he meant: ". . . The present Hospital Survey and Construction Act should be broadened in order to assist in the development of adequate facilities for the chronically ill, and to encourage the construction of diagnostic centers, rehabilitation facilities, and nursing homes. . . ."

Actually, Hill-Burton funds may be used for construction of hospitals for tuberculous, mental and other chronic patients even under present law. Not much H-B money goes in these directions, however, probably because there is little local interest in setting up institutions that will be continuous and heavy financial burdens on the community.

Legislation will be needed if H-B funds are to be made available for separate diagnostic centers, rehabilitation facilities and nursing homes. Bills on these subjects already are before Congress. In this same field, Mr. Wolverton has a bill for F.H.A.-type loans, guaranteed by the federal government, for construction of health facilities. If enacted this might or might not be administered by the Hill-Burton organization.

With the new direction proposed for H-B, there is little likelihood that the program now will be allowed to dry up. Furthermore, if Congress is sending H-B into these new paths, it will have to provide more money than the $65,000,000 voted last year.

The same day the President spelled out his health program for Congress, Mr. Wolverton introduced legislation to carry the Hill-Burton expansion. It would extend the law for three years beyond its present deadline of July 1, 1957. Mr. Wolverton also asked Congress to appropriate $20,000,000 a year for diagnostic or treatment centers; a like amount for chronic disease hospitals; $10,000,000 for rehabilitation facilities, and another $10,000,000 for nursing homes.

MILITARY DEPENDENTS

The military services have President Eisenhower's promise that his administration will propose and push legislation to improve fringe benefits for the officers and men and their families, including more extensive medical care for dependents. Mr. Eisenhower's promise:

"Our defense must rest on trained manpower and its most economical and mobile use. A professional corps is the heart of any security organization. It is necessarily the teacher and leader of those who serve temporarily in the discharge of the obligation to help defend the republic. Pay alone will not retain in the career service of our armed forces the necessary numbers of long-term personnel. I strongly urge, therefore, a more generous use of other benefits important to service morale. Among these are more adequate living quarters and family housing units, and medical care for dependents."

The President wasn't referring to a continuation of the present type of medical care for dependents. He well knows that medical care is furnished in a hodge-podge pattern, with some families receiving complete service and others—those living afar from military hospitals—receiving nothing. He wants all families to receive the same care, and he wants this care to be guaranteed.

Defense Department is preparing a bill to carry out the President's promise, but at this writing it had not been introduced.

OTHER BILLS

Aside from projects of direct interest to hospitals, the Administration has revealed that it wants Congress to enact a score of other bills involving health and medicine.

Mr. Eisenhower has informed Congress that he thinks greater allowance should be permitted in income tax deductions for medical care expenses; on this he has the full support of Chairman Daniel Reed and most members of the House ways and means committee.

The President also is firmly convinced that the federal government isn't doing enough to rehabilitate the handicapped. On this he declares:

"The program for rehabilitation of the disabled especially needs strengthening. Through special vocational training, this program presently returns each year some 60,000 handicapped individuals to productive work. Far more disabled people can be saved each year from idleness and dependence if this program is gradually increased."

Although this already is a comparatively expensive federal program ($23,000,000 this year), it is likely to be expanded.

In line with the trend noted in Congress last year, the Administration also wants adequate money appropriated to "encourage medical research in its battle with such mortal diseases as cancer and heart ailments. . . ." U.S. expenditures of all sorts for medical research now are estimated at close to $100,000,000 a year.

In two of its medically-related proposals in the social security field, the Administration faces the prospect of determined opposition from the American Medical Association.

The Administration is holding fast to its demand that physicians not be exempted when social security coverage is extended to another 10,500,000 persons, as the President has requested. The A.M.A. has repeatedly voiced its opposition to compulsory coverage. Instead the doctors want to be given income tax advantages now enjoyed by corporation employes so they can set up their own retirement programs. There appears to be no way at all to compromise this question. In the A.M.A.'s favor is the fact that the ways and means committee appears not to be as anxious as the White House to extend coverage to groups who don't want to come under social security.

The second controversy is shaping up over a proposal for a "waiver of premium" provision in social security. This plan, advanced and rejected in the past, is designed to ensure that a worker on reaching retirement age will not have his pension reduced because of periods of disability when he was unable to pay into the Old-Age and Survivors Insurance fund.

A.M.A. has objected to the use of medical examinations to establish disability, although the association is not opposed to the ultimate objective of the "waiver of premium." A.M.A. proposes instead that the best 10 working years be used to determine ultimate pension levels, thus eliminating the need for medical examinations with what the association feels is an attendant threat of government interference. On this there is some chance that the A.M.A.'s ideas will be accepted by Congress, if the government's social security experts can be convinced that the "best 10 years" system will work.

The Modern Hospital
FEBRUARY 1954

LOOKING AROUND

Sign of the Times?

A HOSPITAL in New Hampshire has just announced a reduction in its ward rate from $10 to $9 a day.

Anesthesiology Switch

ACCORDING to a survey conducted recently by the American Society of Anesthesiologists, 83 per cent of its members are practicing on a private, fee-for-service basis. It is understandable that the society's officials should refer to this figure with considerable pride, since it suggests that anesthesiologists enjoy the benefits of private practice, if they are benefits, to a greater extent than physicians generally do; a report published in 1953 by Dr. H. G. Weiskotten, chairman of the Council on Medical Education and Hospitals of the American Medical Association, indicated that only 79 per cent of all graduates of American medical colleges in the classes of 1930, 1935 and 1940 were in private practice. As a comparatively new specialty, then, and one that we have been led to believe is in constant danger, along with radiology and pathology, of losing its professional virtue because of hospital domination or "exploitation," anesthesiology appears to be holding its own, if not gaining a comfortable margin, against the threat of hospital control.

The fact is, as most hospital administrators know and as anesthesiologists themselves have reported pridefully on occasion, that in the last three or four years many anesthesiologists have switched from salaried to private fee practice. Furthermore, most of the new men entering the specialty have established themselves, like physicians in other fields, in private practice — often supplanting nurse anesthetists who were hospital employes. Certainly the individual anesthesiologist should be free to choose the arrangement under which he wishes to conduct his practice, and, obviously, the great majority of anesthesiologists must prefer fee-for-service. There is evidence, however, that free choice was not the only, nor even the principal, force at work in accomplishing the swing to private practice.

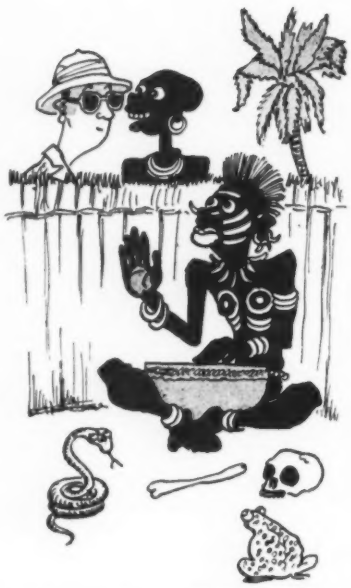
In a recent address, the president of the American Society of Anesthesiologists glowingly described the driving force in the shift to private practice as "an active campaign of information and encouragement among our members, pointing out the moral, ethical and professional values inherent in practicing anesthesiology on the basis of private fee and direct relationship with the patient." Others have described the same program in considerably less complimentary terms, ranging from "thought control" to "union tactics." Surprisingly, these colorful labels have been applied, not by hospital administrators, but by anesthesiologists themselves, and other physicians.

Whatever it is called, the essence of the campaign is that it has been directed against the erring anesthesiologist rather than the hospital which employs him. For the last three years, the salaried anesthesiologist, like a rabbit in a hunting field, has been a frightened, harried creature, menaced on all sides, secure only when he stayed in his underground burrow, communicating with other rabbits. In conversation, correspondence, speeches, bulletins and professional journals, the salaried clinical anesthesiologist has been assailed by the charge that he is unethical and immoral, that he is "splitting fees" with the hospital which is collecting for his services, encouraging corporate practice and socialized medicine, and abrogating his primary responsibility to the patient. Where these tactics of persuasion have failed, a more effective device has been threatened and, on occasion, used. Until last September, it was a requirement of the American Board of Anesthesiology that candidates for certification had to be members of the American Society of Anesthesiologists.

The Society itself has had no rule or regulation denying membership to anesthesiologists whose method of practice is frowned upon. Like the American Medical Association, the Society consists of component state organizations, and it will accept for membership any member of a component society. The component societies, in turn, are free to make their own membership requirements, and some of them have ruled that a salaried clinical anesthesiologist is unfit for membership. Thus in some cases otherwise qualified anesthesiologists were prevented from obtaining certification from the American Board of Anesthesiology because they were on salaries. The secretary of one state society of anesthesiologists, for example, wrote a letter last summer to a professor of anesthesiology at an eastern medical school. "At the meeting of the Society on June 21, 1953," the letter said in part, "following the report of the membership committee, the

Society voted against your request for membership because of your failure to abide by Article VI, Section 6 of the Principles of Ethics of the American Medical Association, which states that 'A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned.' . . . The members of this Society would like to make it clear that aside from this one factor they would be happy to have you join their group, and that they realize that you are only one of many members in good standing in the A.M.A. and A.S.A. whose method of practice is in conflict with this article of the principles of ethics of these societies."

This case is not unique. Some anesthesiologists and other physicians have expressed concern that the Board, which presumably exists for the purpose of certifying professional qualifications, should have concerned itself, however indirectly, with the economics of anesthesiology practice. Board members themselves, on the other hand, consistently defended the requirement until it was rescinded in September, and denied that it was essentially concerned with economic arrangements. "The Board requires membership in the American Society of Anesthesiologists and the American Medical Association for the following reasons," Dr. Curtiss B. Hickcox, secretary of the Board, declared on one occasion. "Participation in the organizations representing American medicine and our specialty is an essential qualification of a person devoting 100 per cent of his time to the practice of anesthesiology. Interest in the organized profession and participation in the opportunities afforded by these bodies is an important indication of professional competence and a recognition of the obligation of an individual to his collective colleagues. This combined membership raises the standards of practice of the specialty through postgraduate education, by means of professional journals, scientific meetings, and development and maintenance of a code of ethics. It relieves the Board of the responsibility of investigating and evaluating the ethical standing in the profession of each applicant. The Advisory Board for Medical Specialties requires satisfactory moral and ethical standing in the profession as one of the qualifications of a candidate for any specialty board." In their insistence that salaried anesthesiology practice is unethical, Board and Society spokesmen have been careful to distinguish between the physician who receives a salary "for teaching or research or charity care or the care of patients who pay no fee," and one who receives a salary for clinical services for which the employing hospital or medical school accepts payment from or on behalf of patients. Only the latter is held to be unethical.



"He says he would like you to assure the B.M.A. of the unqualified support of their West African colleagues in their heroic struggle for the independence of the profession."

Reprinted from "More and More Productions" by Osbert Lancaster.

Notwithstanding their personal exemption from official disfavor, a small group of anesthesiologists in medical school hospitals has consistently opposed the A.S.A. program. Among other things, the medical school group has objected to the A.S.A. interpretation that salaried practice implies a primary responsibility to the anesthesiologist's employer, or hospital, instead of to the patient. "Legally speaking, this may be true," one of the group stated recently, "depending on one's definition of what is meant by 'the primary relationship,' but the implication need not be true and is not true in regard to the strictly medical aspects of the doctor-patient relationship in any of the arrangements with which we are familiar. Many of those practicing on salary can easily produce evidence tending to show that such practice is in the public interest in respect to better organization of service, more complete coverage, and more advantages economically to the public and their hospitals. Arguments on the long-range deleterious effects [of 'corporate practice'] on the specialty are by their very nature not capable of immediate proof."

Another sharp criticism of the A.S.A. was expressed in a resolution passed last spring by the board of regents of the American College of Surgeons. "It is the belief of the regents that to every physician belongs the right of receiving payment for services in whatever way he may elect so long as it is within the ethical principles of the medical profession," the resolution stated, "and that the present attitude and actions of the two groups representing the anesthesiologists are detrimental to the welfare of the individual physician and to the best interests of American medicine."

The resolution was greeted by sharp cries of pain and outrage from anesthesiologists. Whether moved by the college resolution, however, or by the new statement on hospital-physician relationships approved by the A.M.A. and A.H.A. last summer, or by the more recent ruling of the A.M.A.'s Judicial Council holding that salaried practice is not unethical unless exploitation for financial profit is demonstrated by specific finding of fact in the individual case, the American Board of Anesthesiology has now eliminated the requirement that made it mandatory for applicants to be A.S.A. members. Instead, the applicant today must simply "prove to the satisfaction of the Board by such written, survey, oral, and practical examinations as the Board may prescribe that he is qualified to practice anesthe-

siology." The new regulations also provide that "any certificate issued by the Board shall be subject to revocation in the event that the physician certified shall violate the standards of ethical practice of medicine then accepted by organized medicine in the locality in which he shall be practicing . . . or the expulsion from or suspension from the rights and privileges of the American Medical Association or . . . the American Society of Anesthesiologists or any state, county or regional society affiliated therewith."

With 83 per cent of A.S.A. members already on a fee basis, it seems unlikely that the Board will have to rely extensively on this new, or defensive, regulation. Plainly, however, the A.S.A. remains implacably opposed to salaried anesthesiology except in teaching, research or wholly charitable institutions. As explained by John H. Hunt, executive secretary, in a recent statement to The MODERN HOSPITAL, the Society's position is similar to that of the Catholic Church, which admonishes communicants to shun proximate occasions of sin, as well as sin itself. "I know and you know of institutions where the highest quality of medicine is practiced by physicians whose services are sold for a fee, with no effort made by the seller to interfere with the doctor's traditional relationship to his patient," Mr. Hunt said. "But the tendency toward lay control of the physician is present even in such institutions. It is a tendency which in improper hands can lead to lay decisions on the number of cases an anesthesiologist should handle, the methods of procedure he should follow, the type of assistance he should give, and the general duties he should have."

As an example, he cited the case of a well known teacher of anesthesiology at a large and famous hospital. "He was the only anesthesiologist on the staff," Mr. Hunt related. "The patients were charged professional fees, but the anesthesia was given by technicians. The anesthesiologist protested when he was told to be in and out of the many operating rooms as quickly as possible and give a hand where he could. He felt that lives were being sacrificed and that his position allowed him to help no one. As a salaried employe, his activities and his service to patients were not under his control. He felt that his ethical responsibility to do his best for his patients was impaired. His only alternatives were to render poor service or leave, so he left."

This example is an exception, Mr. Hunt quickly acknowledged. "Of course I have selected a minority case," he said. "I am trying to show that it is the principle which is important, and that principles must be designed to prevent abuses by a minority, no matter how small."

Unquestionably, the situation described by Mr. Hunt does exist in some hospitals. Thoughtful hospital administrators recognize that this constitutes exploitation of the physician and should be relentlessly exposed and weeded out by hospital and medical authorities wherever it is found. However, few outside the hard core of fighting anesthesiologists would agree that the existence of such abuses has justified the move against all salaried clinical anesthesiologists. It would make just as much sense to abolish automobiles because some bad drivers cause accidents.

At the moment, an uneasy truce exists between the fee and salaried groups in anesthesiology, unquestionably reflecting the larger unease that prevails throughout the medical profession on the whole question of salaried service, as first one group, then the other, gains an advantage in the arena where medicine's philosophic gladiators take their exercise, the A.M.A. house of delegates. Sometimes both sides gain at once, a circumstance that confuses the scorekeepers as well as the combatants.

Whatever the scorecard of memberships and resolutions shows, however, the issue of full-time medicine will be resolved, when it is finally resolved, more by public opinion than by professional tactics. For an understanding of the public interest involved, we recommend to hospital administrators, anesthesiologists and other physicians a recent essay* by Dr. D. W. Atchley of Columbia University's College of Physicians and Surgeons. "It seems incredible that such an obviously desirable advance should have met the bitter opposition that arose and indeed still exists in certain areas," Dr. Atchley says, recalling the introduction of full-time professorships at Johns Hopkins in 1914. "It was hard for me even from a ringside seat to explain the slow acceptance of this most important of all improvements in medical education and thereby the quality of medicine generally. . . . In this environment the scientist flourishes and the healer is progressively enriched by ever-increasing opportunities to understand and minister to his patients. It is in this atmosphere of teaching, of learning and of eager search for knowledge found in medical schools all over the country that the stature and usefulness of the physician of today has so increased."

* The Healer and the Scientist, by Dana W. Atchley, M.D. The Saturday Review, 36:2 (Jan. 9, 1954).

Whose Choice?

A FRIEND of ours was telling us the other day about his experience with doctors in this age of specialization. When one of his sons became ill a few weeks ago, it developed, Dr. A, the family physician, quickly determined that specialized care would be required. Dr. B, the first specialist he named, was unavailable at the time, as it turned out, and a second specialist, Dr. C, declined to take on the case, which looked difficult and promised to be prolonged, because he was too busy. So Dr. D, although he was known to Dr. A only by reputation, took over. After a short time, however, Dr. D decided that another specialist was needed, so he called in Dr. E, who is now in charge of the case.

Of course, our friend acknowledged, all these moves were made with his knowledge and consent. But this didn't mean much, he added, because the only one of the group he knows anything about is Dr. A, who was left behind weeks ago and has nothing to do now but call up every now and then and ask how things are going.

As far as our friend knows, things are going as well as could be, under the circumstances. "I'm sure we're getting the best care available anywhere, and I'm certainly not complaining," he said. "But I keep wondering what is meant by the phrase 'free choice of physician'?"

Finance Commission Reports

Recommendations include extension of voluntary prepayment, matching funds for indigent care, hospital protection for O.A.S.I. beneficiaries, more use of hospitals by outpatients

FINANCE COMMISSION RECOMMENDATIONS

1. Maximum coverage of the population with voluntary prepayment at the lowest possible cost compatible with the inclusion of adequate benefit provisions. Methods should be developed to enroll the self-employed, farm operators, employes of small firms, pensioners, the unemployed, domestic workers, migratory workers, and others insufficiently covered by present prepayment plans.

2. Use of state and federal funds on a matching basis for limited periods for direct payment to hospitals for services to the medically indigent.

3. Cooperation with appropriate local and other governmental agencies in development of prepayment coverage for individuals and families without income from employment, including retired persons receiving social insurance benefits, beneficiaries of unemployment or workmen's compensation, public aid recipients and social security recipients.

4. Inclusion of a provision in the federal Old-Age and Survivors Insurance program for hospitalization protection for beneficiaries receiving monthly income maintenance benefits, provided administration of such program is the responsibility of state and local agencies, and that protection is provided through purchase of voluntary prepayment coverage or direct payment to hospitals on a reimbursable cost basis.

5. Matching federal grants to states and localities for financing hospital care for indigents, subject to the same restrictions.

6. Experimentation with benefit provisions in hospital and medical prepayment contracts to reduce use of inpatient service by encouraging use of services on an ambulatory basis for diagnostic procedures, and to promote use of home care and convalescent facilities.

7. Inclusion in the cost of prepayment of amounts necessary to finance coverage during absence from work due to disability, up to one year, and elimination of benefit restrictions for the disabled.

8. Studies of actual needs for various hospital services and possibilities for integrating specialized services among hospitals. Joint action among hospitals in purchasing, recruitment and training of nurses and other personnel, obtaining adequate payment from government agencies, and surveying community needs were specifically urged.

9. Education of physicians in hospital economics to avoid unnecessary utilization, duplication of service and waste.

10. Early referral of patients to special facilities for care of chronic illness, convalescence, rehabilitation units or home care programs, to reduce unnecessary prolonged use of general hospital beds in appropriate cases.

WASHINGTON, D. C.—Expansion of hospitalization prepayment plans to cover more people with more benefits, greater use of hospital facilities by outpatients, and better integration of facilities and services among institutions offer the principal means of securing the financial future of the American hospital system, according to the Commission on Financing of Hospital Care. A summary report of the Commission's findings and recommendations was released at a press conference here last month.

The Commission report was released the day before President Eisenhower sent his special message on health legislation to the Congress. The President's proposal to broaden and strengthen voluntary prepayment coverage parallels one of the broad recommendations of the Commission, which saw the failure of existing prepayment plans to cover indigent and medically indigent families, the unemployed, aged and retired workers and others as a major flaw in a hospital system whose first principle was stated to be that "necessary hospital care should be available to all persons in the community without regard for their ability to purchase it."

The Commission was organized two years ago, under the sponsorship of the American Hospital Association, to study the cost of providing adequate hospital service and determine the best system of payment for such service. Membership on the Commission included representatives of hospitals, medicine, education, business, labor and government. "One of the most important effects of the Commission's many meetings and extensive discussions," the summary report stated, "is that the broad base of agreement reached by the Commission has required an understanding and appreciation of many different points of view. Thinking through the problems confronting the Commission has helped bring closer together divergent points of view. The virtual unanimity of thinking as expressed in the Commission's recommendations is not only gratifying but has undoubtedly established a sounder foundation on which to build in the future."

Principal recommendations made by the Commission are shown at left.

Supporting these and other recommendations, the Commission released in its summary report a statement of principles and a few excerpts or "highlights" from the reports of separate

(Continued on Page 160)

PROTOTYPE STUDY: 25 BED HOSPITAL

All the facts about the 25 bed hospital as it exists today—comprising a useful tool for self-evaluation and an adaptive guide to administrative planning

LOUIS BLOCK, Dr.P.H.
Program Coordinator
Division of Medical and Hospital Resources, Public Health Service

MOUNTING appreciation and demand for hospital service in the last 10 years has resulted in increased emphasis on hospital construction in order to meet the growing need for facilities to provide good patient care. Increased deficits and gaps in the provision of facilities occurred during depression and during World War II years. By 1946, in the aftermath of the war, this need became so pronounced it came to be recognized as one of the most pressing health problems facing the nation. The passage of the Hospital Survey and Construction Act of 1946, and the needs and desires of the people and communities themselves, stimulated intense interest in the provision of better services as well as facilities.

The result of such developments has been a coordinated teamwork—one of which, by working together, all groups, hospital, medical and civic, tried to produce the best facility in which the best possible care could be given.

This teamwork and consultation of all groups in the development of the present-day hospital program required that three basic areas of information be looked into and studied in order to permit sound planning. These areas were community needs, facility design, construction and equipment, and functional hospital operation and management.

Concerning the first, community needs, an approach has been made through the development of the state hospital plans under the Hospital Survey and Construction Act (Hill-Burton program). Experience in this area, plus the growing field of competent hospital consultation, has shown some progress. Despite this, there is still needed in order to round out and complete this approach, the development of sound "Elements of Community Measurement." This may well take the form of tested and proved methodology for application to individual community needs. Studies of the many objectives and measurable factors necessary to such a development are in process today—with many groups, official and nonofficial, educational and operational, working together in this area.

In the second area, hospital design, construction and equipment, much has been done. Perhaps the best recognized achievement has been the development of the "Elements of the General Hospital." The provision of such guides for planning has stimulated research, has developed educational mechanisms, and has raised the general level of hospital architecture, design and construction to a point never before reached in this country.

Concerning the third area, hospital operation, certain advances have been made. Much of the advancement has been through increased consultation from competent consultants at state, local and individual levels and through the development of limited guides and informative details. However, in this particular area there has not yet crystallized the basic guides necessary to real community measurement and to functional hospital design.

The importance of all of the aforementioned developments lies in the fact that they supply general information upon which to plan for specific requirements. They are the target drafts which must be adapted to assure that they fit local conditions and needs.

Quite often the statement is made that no two hospitals are alike. It is recognized, and true, that although basic similarities in function do exist, each hospital is an entity in itself to a certain degree. As such it presents variations from a guide pattern because of local situations and local differences. Despite this, application over the years of existing guides in planning has established their usefulness.

Many times it has been recognized that a written program of hospital operation is necessary properly to develop both the areas of community needs and hospital design, construction and equipment. Without knowledge of hospital operation, little real advancement could be made in either of these areas. Such written programs are based upon measurable facts—and such facts are, especially in the area of hospital operation, largely obtained from statistics.

Hospital statistics may be national, regional, local or individual in scope. As one progresses from the individual to the national picture, the information obtainable moves from the specific to the general and from narrowly defined to much broader areas. Necessity has dictated such generalizations with regard to national data because of the magnitude of the job and the expense involved in obtaining specific information regarding the hospitals of the United States.

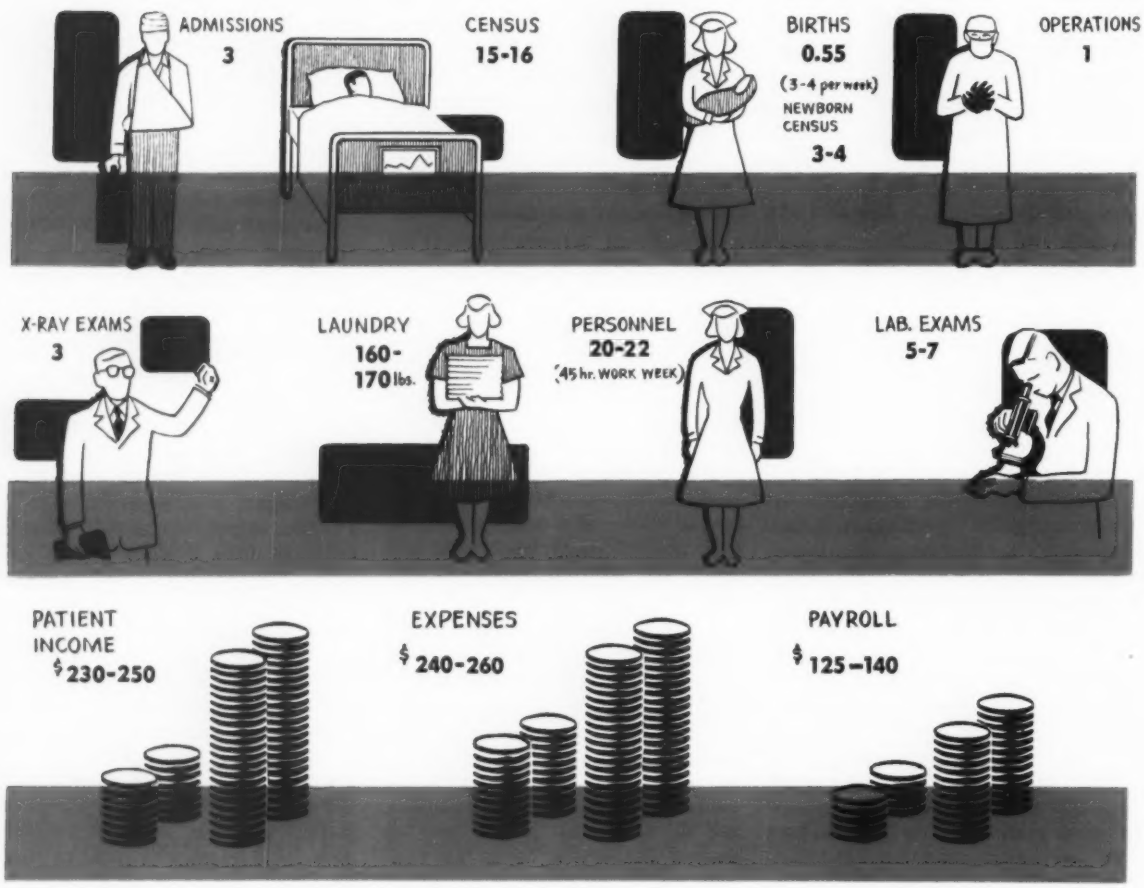
We have had to be satisfied with current reporting and data on numbers of institutions, beds, broad utilization information, and gross personnel and financial data. Prior to 1945, the major source of hospital information was the annual hospital number of the journal of the American Hospital Asssociation. Since that time the American Hospital Association has contributed national, regional and state summaries of general information and, as specific one-time studies, certain additional specific information.

Despite the fact that we rely heavily on these two sources of data for planning and programming for hospital services, there does exist a tremendous reservoir of specific and detailed information regarding hospital activities and operations in various individual hospital, local and regional groups. It was this attempt to utilize such information that led to the development of these prototype studies.

This is the last in a series of prototype developments. The first of the series, "The 50 Bed Hospital," appeared in the June 1953 issue of The MODERN HOSPITAL; the second, "The 100 Bed Hospital," appeared in the October 1953 issue, and the third, "The 200 Bed Hospital," appeared in the January 1954 issue of The MODERN HOSPITAL.

The reasons motivating the development of this series were also explained in the first of the series. In all of them it was emphasized that there was a need for such information; that certain of the data were arrived at through applying the proportionate variations from local averages in the areas where studies had been made to national averages; that a "prototype" is generally defined as a pattern that describes "what is" rather than "what should be"; that emphasis on the typical or average is beset with many dangers if not properly applied, and

AN AVERAGE DAY'S ACTIVITIES



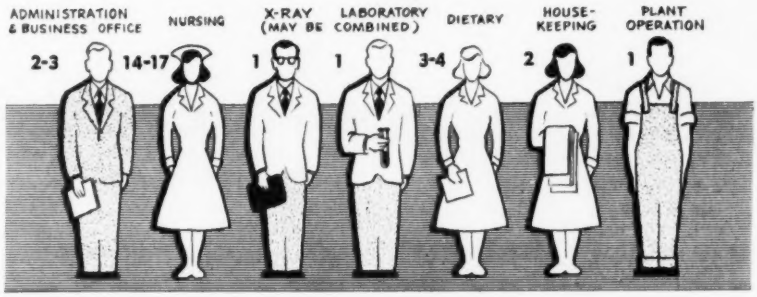
In this prototype of hospital operation for the 25 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

that it can be a useful tool for self-evaluation and as a general guide to administrative action when adapted to one's particular needs.

The following prototype is the fourth example of applying these technics and facts to a 25 bed nonprofit, general hospital.

In this prototype of hospital operation for the 25 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.

AVERAGE NUMBER OF PAID PERSONNEL



BED DISTRIBUTION

Major. In at least half of these hospitals, medical, surgical and obstetrical patients have beds specifically set aside for their use. For this reason they are considered as major services to such a hospital type and size group. In many instances it is common practice to combine medical and surgical services. This combined service accounts for 70 per cent of all beds, and obstetrics for 30 per cent. This means that the average 25 bed general hospital has 17 to 18 medical and surgical beds and 7 to 8 obstetrical beds. In fact, in the 25 bed hospital the only assignment of beds is made for obstetrical patients. The remaining beds are usually classified as unassigned, *i.e.* to be used for medical, surgical and other patients as needed. The foregoing bed distribution will be affected by assignments to additional services discussed hereafter.

Additional. In addition to the basic groupings of patients found in more than half of these hospitals, the 25 bed general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional services. The table indicates these additional services, frequency of their occurrence, and average number of beds assigned them.

Bassinet Distribution. The average number of bassinets for newborn is higher than for obstetrical beds, 9.

Three out of every 4 of these have infant incubators. They average 1 to 2 such units per hospital.

Only 1 in 10 has special nurseries for premature infants.

Closed Beds. One hospital in 25 reported beds closed for all reasons. They averaged 9 to 10 closed beds per hospital.

One hospital in 60 had beds closed for lack of personnel. They averaged 13 beds per hospital.

One hospital in 45 had beds closed for reasons other than personnel. They averaged 7 beds per hospital.

UTILIZATION

The kind, type and number of patients admitted to the 25 bed general hospital are as follows:

Admissions. An average of 1000 patients are admitted during the year, averaging 40 admissions per bed per year.

Births. There are approximately 200 live births during the year. Of this number, 10 to 15 will be premature. There will be an average of 2 sets of twins during the year.

Patient Days of Care. The hospital provides around 5500 to 6000 days of care. Of this number, approximately 1250 will be for obstetrics and 4250 to 4750, medical and surgical.

Newborn Infant Days of Care. In addition, approximately 1100 to 1400 days of care are provided for newborn infants during the year.

Average Daily Census. An average of 15 to 16 patients is cared for daily.

An average of 3 to 4 newborn infants is cared for daily.

Percentage of Occupancy. The average annual percentage of occupancy approximates 58.

Newborn occupancy approximates 33 to 44 per cent.

Average Length of Patient Stay. Length of patient stay averages 6 days.

This varies by type of accommodation as follows:

Private	5 to 6 days
Semiprivate	4 to 5 days
Ward	7 to 8 days

Semiprivate patients usually stay a shorter time than do either private or ward patients. Among the usual explanations for such an occurrence is that the pressure of finances requires the semiprivate patient to get back to gainful employment as soon as possible. Private patients may be in a better position to afford slightly longer convalescence in the hospital. Ward patients, on the other hand, may have other factors dictating or affecting the length of time they stay. Among these factors are usually those of more advanced cases of illness and home conditions not conducive to convalescence.

Length of stay for all patients varies by diagnosis as follows:

Medical	9 to 10 days
Surgical	6 to 7 days
Obstetrics	3 to 4 days
Pediatrics	5 to 6 days

Frequency of Additional Services

Patient Group	Frequency of Occurrence	Average Number of Beds Assigned
Pediatric	1 in 5 hospitals	4
Isolation or contagious	1 in 13 hospitals	2
Chronic	1 in 25 hospitals	4–5
Nervous and mental	1 in 100 hospitals	7
Tuberculosis	less than 1 in 100 hospitals	...

Gynecology	4 to 5 days
Genitourinary	7 to 8 days
Orthopedics	9 to 10 days
Ear, nose and throat	1 to 2 days
Ophthalmology	6 days
Other	4 to 5 days

Almost four-fifths of all patients are discharged within one week. The per cent of patients discharged according to length of stay shows:

Length of Stay	Per Cent	Cumulative
1 day	24	24
2 days	7	31
3 days	8	39
4 days	13	52
5 days	12	64
6 days	9	73
7 days	5	78
8 days	4	82
9 days	2	84
10 to 13 days	9	93
14 to 20 days	3	96
21 to 30 days	2	98
31 days and over	2	100

PERSONNEL

Numbers. The average number of paid personnel approximates 24 to 27, excluding interns, residents and students.

This amounts to an average of 158 full-time employes per 100 patients, 1 employe per bed, or 1.6 to 1.7 employes per occupied bed.

The average number of paid employes is distributed departmentally as follows:

Administration and business office	2- 3
Nursing	14-17
X-ray	1
Laboratory	1
Dietary	3- 4
Housekeeping	2
Plant operation	1

(X-ray and Laboratory: May be combined)

Job Vacancies. Seven in 10 hospitals reported job vacancies. Of those reporting vacancies, 7 in 10 had vacancies in graduate nurse positions. They averaged 2 to 3 such vacancies per hospital.

Of those reporting vacancies, 3 in 10 reported them in positions other than for graduate nurses. They averaged 2 such vacancies per hospital.

Governing Board. The average size of the governing board is 9 to 10 members.

Volunteers. One in 6 hospitals has volunteers other than women's auxiliaries. The average is 10 to 11 such workers per hospital.

Women's Auxiliaries. Better than 1 hospital in 3 has a women's auxiliary. Their average membership is 136, and they have 11 members working in the hospital.

Administrator. The chief administrative officer is a physician in 1 hospital in 5, a graduate nurse in almost 1 hospital in 2. In 3 hospitals in 8 he is neither a physician nor a nurse but has some other background.

In 1 hospital in 14 the administrator is a graduate of a college course in hospital administration.

In 9 hospitals in 20, the chief administrative officer is a male.

SERVICES

Major. The following services are found in more than half of the existing 25 bed general hospitals:

X-ray diagnosis	17 hospitals in 20
Medical records department	1 hospital in 2
Metabolism apparatus	7 hospitals in 10
Clinical laboratory	7 hospitals in 10
Electrocardiograph	3 hospitals in 5

Additional. Services that might be provided but are generally found to occur in less than 50 per cent of the facilities are considered additional. The following indicates some of these services and the frequency with which they are provided within this hospital size and type group. Certain of these additional services may be provided through arrangements with other hospitals and sources. Such arrangements are not reflected in the frequencies shown.

X-ray therapy	1 hospital in 11
Women's auxiliary	1 hospital in 3
Patients' library service	1 hospital in 4
X-ray, routine chest on admission	1 hospital in 9
Postoperative recovery room	1 hospital in 25
Children's educational program	1 hospital in 100
Pharmacy department	1 hospital in 5
Physical therapy department	1 hospital in 7
Outpatient clinic	1 hospital in 5
Social service department	1 hospital in 33
Occupational therapy department	1 hospital in 50
Medical library	1 hospital in 4
Central supply	1 hospital in 3
Blood bank	1 hospital in 3
Cancer clinic	1 hospital in 33
Dental department	1 hospital in 16
Electroencephalograph	1 hospital in 50
Mental hygiene clinic	1 hospital in 100
Training course, auxiliary nursing personnel	1 hospital in 25

DEPARTMENTS

Medical Staff. The average 25 bed general hospital has 18 staff appointments. Of this number, 9 are active, 1 associate, 4 courtesy, 3 consultant and 1 other type of appointment.

Almost 9 in 10 of these hospitals have a chief of staff.

Only 1 in 3 has a chief of services.

Seven in 10 have a written set of regulations.

Seven in 10 have regularly scheduled meetings of the staff.

Better than 2 in 5 have standing committees of the staff.

Two hospitals in 5 allowed nonstaff members to practice in the hospital.

Three hospitals in 5 have restrictions on staff physicians' surgical privileges.

Two hospitals in 5 provide examining rooms primarily for ambulatory patients of the medical staff.

One hospital in 6 reported physicians' offices in the hospital or on the hospital grounds for seeing private ambulatory patients.

Operating and Delivery Rooms. The 25 bed general hospital has 2 operating rooms; 1 major and 1 minor. The minor operating room is most likely used as an emergency room also, or vice versa.

The average number of operations approximates 375 per year. Of this number, about 150 are major and 225 are minor.

The hospitals average about 1 delivery room. There are about 200 deliveries per year.

X-Ray. Approximately 1050 to 1075 x-ray examinations are given during the year.

Approximately 35 per cent of the hospitals have physician staff members specializing in radiology; 3 per cent have them full time and 32 per cent part time.

Better than 9 in 10 hospitals have x-ray facilities available to private ambulatory patients of physicians.

Laboratory. Approximately 2000 to 2500 clinical laboratory examinations are performed annually.

Twenty-five per cent of the hospitals have physician staff members specializing in pathology; 22 per cent have them part time, and 3 per cent have them full time.

Three hospitals in 4 have all tissue removed in surgery routinely examined by a pathologist.

Better than 9 in 10 hospitals have laboratory facilities that are available to private ambulatory patients of physicians.

Blood Bank. One hospital in 3 has a blood bank. Those having blood banks issue 142 units of 500 cc. each per year. This amounts to an average of 5.3 units per bed per year.

Their average stock amounts to 5 units.

Their bleeding capacity is 3.

Their source of blood is as follows: 27 per cent from donors, 2 per cent from other hospital banks, 2 per cent

(*Continued on Page* 134)

Minority report on the tissue committee:

Why Pick on the Surgeons?

Medical practitioners bury their mistakes, too, a pathologist points out, and adds that the tissue committee is a double-edged weapon that must be handled with caution

S. M. RABSON, M.D.
Director, Department of Pathology
St. Joseph Hospital, Fort Wayne, Ind.

THE surgical tissue committee has been established perhaps chiefly as a means of meeting popular suspicion that surgery is not always therapeutically required. It is not unlikely that the public considers surgery synonymous with visceral extirpation and that, basically, it is rebelling not against the use of the scalpel but against the loss of organs with its psychologic as well as physical sequels. As reluctant as one is to part with any organ, even for well established indications, the sense of outrage at its apparently unnecessary removal is pronounced.

WHAT HAS BEEN GAINED?

That it is the loss of viscera which leads to the institution of a tissue committee is proved by the usual method of assessing the value of the committee —a decline in, say, the number of normal oviducts and ovaries sent to the laboratory. What has been gained? Has the professional competence of the oophorectomist been improved as a result of the committee's investigation, and are the ethical standards of the salpingectomist thus elevated? In fact, a fall in the number of extirpated normal viscera after a tissue committee gets to work does not reflect a basic improvement in surgical practice, but is confirmatory evidence that the surgeons concerned have no place on the hospital's staff. To permit them to remain may be a refusal to face the problem. The "success," then, of the committee may be compared to the efficacy of cortisone in blanketing symptoms while the underlying disease progresses.

The use of the pathologist's report as the main piece of evidence in assessing the status of the operation and its indications is not unfraught with danger. It represents, it is conceded, a fact, but the truth about the operation consists of many more facts, some readily ascertained and others laboriously verifiable. Such prominent use of the report assists the committee in placing a surgeon in the unenviable and unjustifiable rôle of proving his innocence, rather than requiring the committee to expose his guilt. The pathologist's report basically is the opinion of a consultant who is attempting to assist the attending doctor in the care of the latter's patient; other uses of the report may be legitimate, but some of these may tend to defeat the genuine reason for the preparation.

Another question reasonably presents itself. Medical specialties are also practiced in the hospital, yet they are left to work without a prying committee. The sin of omission on a medical service can be as common as the sin of commission in a surgical unit, and there may be good arguments mustered to maintain that the former is more common. Contrary to often expressed assertions, it may be said that the knife is usually not taken up without some thought about its dangers as well as blessings. It is this deterring thought which is missing in the nonsurgical branches, thus, perhaps, relieving the atending physician both from a sense of positive (physical) intervention and from a sense of guilt at the failure of the patient to respond to his ministrations. He is further ensconced in his position by the baneful misuse of "radical" and "conservative," with the psychologic comfort of associating "radical" with surgery and "conservative" with nonsurgery.

WOULD RESENT INQUISITION

All this logically leads to the idea of the formation of a general inquisitorial committee which, one may be sure, would draw the bitter protests of those who now readily subscribe to or accept the principles of a tissue committee. Such a general committee would need far more extensive and often subtle evidence to conduct most of its business than the readily available pathologist's report on which the tissue committee chiefly and superficially wisely leans.

Every case with protracted hospital course, not to mention the fatal instances, would have to be investigated. Those patients in whom the *vis mediatrix naturae* had overcome injudicious medical care necessarily would not be studied since there would be no official way to know of their existence; besides, they would have long since left the hospital. There is no need to

belabor the point; a general inquisitorial committee would be impractical, whatever its other more serious deficiencies.

Untouched by the tissue committee is the far more serious problem of basic surgical judgment and execution. Attempts to meet that problem should be prophylactic; the education of the surgeon—before he joins the hospital staff—is paramount. Closer scrutiny of applicants to staff membership, surgical and medical, is necessary and should include investigation of conduct and progress in internship and residency. Not only skills need to be evaluated, but also ethical standards. State medical licensure is not a guaranty of the latter, nor should it be accepted as a substitute for the legitimate evaluation of the applicant. State medical licensure indicates only that the applicant has satisfied basic technical requirements; the hospital has the right and obligation to demand more.

The attempted demolition of what has already been set up does not require the wrecker to substitute something else. An uncultivated field may be permitted to grow, when an eyesore has been removed, until wiser members of the community take the time and reflection to plan a better structure.

Were it demanded that another plan of procedure be offered, I would suggest the study of all cases, living and dead, regardless of their outcome. At present, the hospital staff meeting is presented with stories of success, while the committees investigate the record of failure. Each week a member of the staff might present several consecutive and unselected cases (taken from the files by the records librarian) before a short general staff meeting, discussing the problems encountered and answering questions from the audience. Within each year or two, every physician on the hospital staff would be subjected to the scrutiny of his peers. In this way, data would accumulate for the use of that hospital organ charged with the approval of retention of staff members.

The situations which have provoked the formation of tissue committees are but facets of the genuine and only problem: the relations of physician, patient and hospital to one another. That problem cannot be satisfactorily approached and adequately handled without a guiding philosophy. Such a philosophy is unfortunately conspicuous by its absence, else it would long since have entered into any discussion. Its absence is no accident, and may be linked to shifting political, social and economic philosophies on the national and international scenes. Until there is a good reconciliation between these philosophies, or until one of them carries away the victory over the others, the patient-hospital-doctor trinity will have to be dealt with in pragmatic fashion. The pragmatic approach, it should be remembered, usually requires constant revision.

A surgeon raises some questions about

Unnecessary Use of Blood

R. STERLING MUELLER, M.D.
New York City

THE availability of blood for transfusion is great, its use routine, free and often casual—so much so that transfusions are given unnecessarily. Frequently the patient would do just as well, and in some instances better, if no blood had been given. Patients expect transfusions when they are ill, and in fact often demand the use of blood. In surgical cases when hypotension occurs without blood loss, frequently little effort is made to determine its cause. Instead a transfusion is given almost automatically.

More than 3,000,000 units of blood are used each year in the United States. In the Roosevelt Hospital, New York City, 3600 transfusions were given last year. There is always a certain degree of hazard present when a transfusion is given. Reactions, except those caused by misgrouping, are fortunately rarely fatal. Hepatitis owing to blood or plasma is increasingly frequent. Percentage figures for this type of transmitted hepatitis are often difficult to determine. It has been stated that a patient receiving 25 or so blood transfusions stands an excellent chance of developing hepatitis. The usual figure given for homologous serum jaundice from blood is around 1 to 2 per cent. The incidence of hepatitis from blood transfusion depends on the degree of selection used in obtaining donors. When plasma is stored by refrigeration or in the desiccated form the virus is preserved. The percentage of cases developing infectious hepatitis is naturally much higher with plasma and depends on the number of donors in the plasma pool. For this reason the use of plasma has gone into the discard. Hepatitis from plasma transfusions varies from 15 to 20 per cent or more.

Recent work[1] has shown that if plasma is not stored in the desiccated form or by refrigeration, but is kept at room temperature for six months, the virus of hepatitis dies and the plasma may be given with safety after, of course, its sterility has been determined. We are storing plasma at room temperature at present for use after the six-month period has passed.

Operations frequently are required in patients with liver damage caused by cirrhosis, previous hepatitis, or biliary obstruction. Whole blood is naturally a necessity for many of these operations. In such cases there is too much risk in using bank blood. These cases, barring a sudden emergency, should receive blood taken from a professional donor, one who has given

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Given before the twenty-sixth annual Graduate Fortnight of the New York Academy of Medicine at the Roosevelt Hospital, Oct. 22, 1953.

[1]Allen, J. G., Inouye, H. S., & Sykes, Carolyn: Homologous Serum Jaundice and Pooled Plasma — Attenuating Effect of Room Temperature Storage on Its Virus Agent, Ann. Surg. **138**:476, 1953.

Photographs by M. Tannenbaum, Denver.

Top: Weld County General Hospital, Greeley, Colo., seen from the east. Two-story wing in foreground is for the department of public health. Bottom: From the southwest: two nursing wings and public health wing.

THE MODERN HOSPITAL OF THE MONTH

Weld County Covers the Health Front

Facilities of Northern Colorado's new medical center embrace all three phases of health care: acute, chronic and preventive

HENRY H. HILL
Administrator
Weld County General Hospital, Greeley, Colo.

WELD County, Colorado, is one of the richest agricultural areas in the nation. The traditional community spirit of the people dates back to the old Union Colony of the Horace Greeley era and is manifested today in the tremendous support of public health and welfare. Weld County General Hospital portrays a concrete example of this support.

The original hospital was started in 1904 and like most hospitals of that era was added to from time to time until it reached a capacity of more than 100 beds. When more space was needed neither the land area nor the building was suitable for further expansion. Certainly functional planning was impossible without prohibitive expenditures. Thus the new Weld County General Hospital came into being. It stands today one of the most modern and complete in the West. There are many larger but few that can equal it for beauty and function. Fisher & Fisher of Denver associated with Sidney G. Frazier of Greeley were the architects; Milo S. Ketchum of Denver was the consulting engineer, and Samuel R. Lewis & Associates of Chicago were the mechanical consultants.

Parking, the No. 1 problem of the country today, we feel has been solved. Beside the entrance a large paved parking lot for the public has been installed. In the rear where supplies, ambulances and the staff enter is another paved lot completely separated from the public parking. The building is in approximately the center of 20 acres of grounds surrounded on all sides by paved thoroughfares. Nine acres of lawn with tree and shrubbery landscaping lend it park-like beauty.

On the first floor are the business offices: administration, accounting, admitting, credits, pharmacy, snack bar, and two nursing wings which service pediatrics, isolation and a small area for psychiatry. The second floor services are medical nursing, medical records, laboratory, blood bank, x-ray and the doctors' lounge and library. The third floor is for surgery and surgical nursing. There are four major surgeries, one minor surgery, an orthopedic surgery, a cystoscopy room and a plaster room with fluoroscopy and darkroom facilities for each of the latter. The fourth floor serves the delivery room, labor rooms, nurseries and obstetrical nursing. There are no wards for adults in the hospital; only private rooms and two-bed rooms are offered. The fifth floor has a large solarium and sundeck opening toward the mountains and also on this floor

(*Continued on Page 62*)

Below: Plan of the basement which houses kitchen, dining rooms, central supply, and storage areas. Picture shows the kitchen with tray conveyor in action. Above and right: The entrance lobby looking toward parking lot, and the plan of the first floor showing position of public health wing.

Below: Plan of the second floor showing medical nursing wings and laboratory and x-ray facilities. Photograph shows playroom in pediatrics department for convalescents. Above and right: Typical nurses' station at junction of the corridors, and plan of the third floor, devoted to surgery.

Left: Lobby showing receptionist's desk and free form fresco. Below: Close-up of the fresco.

(Continued From Page 59)

are quarters for interns and residents.

The service or ground floor houses the kitchens and cafeteria, emergency room, central supply, purchasing department, physical therapy and the auditorium. The basement contains the boiler room, shops, dishwashing room, equipment rooms, morgue and autopsy rooms, laundry and large storage rooms.

Dial telephones are used for administration throughout the building and all admissions, dismissals, charges and orders are conveyed by pneumatic tubes. Intercommunication between nurse and patient is standard equipment and oxygen is piped from a cascade system to each room and bassinet. Microphones in surgery and on nursing floors which are connected to dictating equipment in the medical record office assist the physician in keeping his charts current with a minimum of effort. Four elevators, three dumb-waiters, a food conveyor and a freight lift care for vertical transportation. Central food service is used throughout under the supervision of three dietitians.

A paging system with a master station in the accounting office and speakers in each department where charges originate has helped to solve the problem of late charges. When dismissals are received the bookkeeper pages the nursing floor, central supply, x-ray, laboratory, pharmacy and any other department indicated to obtain all charges before presenting the statement to the cashier for collection. This system is separate from the regular paging system for the hospital.

A nurses' training program is carried on with the University of Colorado School of Nursing whereby senior students are trained here on a six-weeks' rotating basis. This plan helps the student, the hospital and the school of nursing. These students also receive on-the-job training in public health nursing through the facilities of the Weld County Department of Public Health. They visit homes with the public health nurse and work occasional assignments at doctors' offices. In this manner they follow the patient from the hospital to the home and then to the doctors' office for follow-up care—truly, a well rounded training program.

A two-story wing for housing the department of public health is a part of the structure. It can be entered through its own lobby or from the hospital lobby. It contains the bureau of vital statistics, a complete public health laboratory, as well as the regular departments of public health such as the visiting nurses, sanitarians and the various clinic activities, including immunization, preschool, tuberculosis, crippled children, mental health, child health, dental and prenatal. The facilities of the hospital were so planned that the laboratory, x-ray and physical therapy departments are next to the public health area. This makes possible efficient coordination of efforts between the hospital and the department of public health. Each organization administers its own affairs but a spirit of cooperation exists that would not be possible if the services were separated by any great distance.

An important problem facing many hospitals today is the procuring of sufficient funds for the cost of indigent care. This problem, too, has been solved here by the county's paying the complete cost of this service to the hospital.

The medical staff of 57 doctors has developed an organization for the control of privileges and services which guarantees safe medical and surgical care to the patient. Each service is organized by its own chief and an audit committee examines each chart each month. There was some resistance to this procedure at first, but today the doctors are as proud of their records as the board of trustees and the administration are. Twenty-one per cent of these staff members are members of American boards.

The medical staff donates its services for the medical and surgical care of indigents. Inasmuch as these patients total about 20 per cent of the patient load this is no mean contribution. In addition, the medical staff has contributed more than $48,000 for equipping the x-ray department.

The hospital was planned for the future as well as the present. Provision has been made for the addition of a

CONSTRUCTION DATA

Hospital area in square feet	142,876
Public health wing	14,521
Total	157,397
Hospital cubic area, in feet	1,538,076
Public health wing	152,528
Total	1,690,604
Bed capacity	220
Total cost including Group 1 equipment	$2,432,785.00
Cost per bed	$11,058.00
Cost per square foot	$15.12
Cost per cubic foot	$1.44
Total cost of project including site, landscaping, Groups 2 and 3 equipment, architect's fees and miscellaneous items	$3,250,000.00
Cost per bed based on total project cost	$14,700.00

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

future wing of 120 beds. The services are so designed that this additional patient load can be handled without any structural change except the simple addition of the nursing wing. Wiring and piping lead to the future junction point where they will be readily accessible when needed.

The old hospital just vacated is being remodeled to serve as a chronic, convalescent and geriatrics institution and was to be completed late last year. The county department of public welfare will be housed in this building which is only a few blocks from the new hospital. These health facilities embody three phases of patient care: acute, chronic and preventive; have promoted civic pride, and created a feeling of security for the physical well-being of the community. The patients regardless of racial or financial status receive safe medical care.

View down a typical corridor. Note protective wall bumpers.

Architectural Elements of Weld County Hospital

ALAN FISHER
Fisher and Fisher, Architects, Denver

PERHAPS the most remarkable element of structural design within Weld County Hospital is that all exterior columns have been deleted from the two wings housing the nursing or bed area. Thus, the exterior wall treatment or, perhaps better described, exterior skin treatment, is completely flexible throughout these areas to express the use or arrangement of the internal areas. It was further felt that such flexibility may prove favorable in any use changes that may be advised in the future.

The bed areas, therefore, consist of cantilevers springing from and supported by the double row of corridor columns and the flat beam between the rows of columns constituting the corridor floor. The flat beam between the columns is approximately 16 inches thick and the cantilever slabs, which extend 18 feet out from the columns in the clear, taper to an approximate 5 inch thickness. Three feet of the 18 foot projection constitutes the protective overhang.

Two inch square steel newel-type columns comprise the mullions to which the steel sash is attached. These mullion columns are independent of the structural cantilever slabs and work free within square receptacles attached to the slab above.

Reference is made to the window airiness resulting from the absence of exterior beams at the heads. Continuity of the ceiling's upward and outward slope from interior to exterior is preserved. Low window sills (18 inches high), so that the bed patient may observe the near foreground, have been made possible by the absence of beams. Exterior spandrel material below the windows is porcelain enamel steel.

Other service portions of the hospital where the cantilever slab system is not used are typical reinforced concrete construction closed by Harvard red stiff-mud brick and areas of applied porcelain steel in gray-green color reminiscent of sagebrush or new spruce buds.

Architecturally, the essence of the structure is simplicity and directness; all architectural effects emanate from natural forms resulting from plan requirement. Color also plays a basic part in the design not only as a result of the choice of exterior materials for texture and color, but also from the selection of interior color as the cantilever system and openness of nursing areas, described herein, expose internal sloping ceiling areas to the outside. These areas, therefore, became exposed to the exterior and the selection of deep tones became basic in importance.

The internal colors mentioned are again the spruce to the sunny exposures and terra cotta to the north exposure. In the matter of these internal colors, the two aforementioned colors are countered throughout nursing areas with a color used commonly to both, a deep warm gray. In all cases, the gray is used on the window wall and the two end walls and the two positive colors are used opposite windows and on the ceiling. Through the use of the deep positive colors, the opposite wall to window glare is eliminated, and the patient in bed faces no reflecting ceiling surfaces. Lime yellow, cocoa brown and white constitute the remainder of four colors and white specified for the hospital.

The character of the entrance lobby was purposely divested of all elements that might suggest pomp or formality. The keynote of form, material selection, and color is to create warmth, charm and friendliness. The exterior red brick is introduced into a portion of the lobby to aid transition, outside to inside. A large and well filled planting box carries from the exterior, through the glazed vestibule, and becomes a feature of the lobby. Another feature of the entry is the presentation of a large true fresco within a free form applied directly onto a portion of the interior brick wall. Purposely, the subject matter of this fresco, executed by Louise Emerson Ronnebeck, a senior artist of this area, is completely abstract and without provocation to any faction, interest or group. It is as profound in controversial issue as a bowl of blossoms of lupine on a mountainside. The reaction to this is proving to be good.

Blue Cross Will Endure—If

all Blue Cross and Blue Shield plans work as one to meet national health needs on a national level

ABRAHAM OSEROFF
President
Hospital Service Association of Pittsburgh

BLUE Cross is without value unless it provides benefits that meet the needs of its members and unless it continues to make those benefits available at a price the great majority can afford to pay. The ultimate evaluation of Blue Cross will be made on that basis, and it will be evaluated in terms of what it has achieved as a national program as well as what it has accomplished in local areas; the answer to the question, "How well has Blue Cross met its objectives?" will be given by the national public.

What we do within the next few years may well determine whether the philosophy and application of Blue Cross principles are destined to endure —or be written off as the last brave but inadequate attempt to meet the problems of health care on a voluntary basis. That is true for Blue Shield as well as for Blue Cross, since the programs are inseparable in terms of public need. They will be weighed on the same scale.

I believe that Blue Cross and Blue Shield will endure, and that the fundamental concepts which have been responsible for our success and usefulness so far will be preserved. But I believe that this will be possible only through recognition of the need for greater understanding among ourselves; greater coordination of our activities, and greater unity in the approach to our mutual problems.

We live in a favorable political climate. The present administration encourages voluntary initiative in the provision of community and national health services, but this is predicated on the satisfactory performance of the voluntary programs now in existence. It is, at the very best, provisional approval. The next few years must be years of planned growth toward a stronger local and national position—not for Blue Cross alone, nor for Blue Shield alone, but for Blue Cross and Blue Shield together.

Because steadily increasing membership is the most convincing evidence of success in meeting our objectives, we usually measure our progress in terms of enrollment. Our enrollment tells the story of how well, or how poorly, we have related benefits to need, and cost to ability to pay. It is the starting point for any program of self-examination. It can be the first major symptom of a functional disorder, or the first assurance of an improved condition. We may have other standards by which to

Adapted from a paper presented at the Blue Cross-Blue Shield office management workshop, 1953.

Two Threats to Blue Cross Survival:

COMMERCIAL COMPETITION AND RISING COSTS

THE continued growth and development of Blue Cross are dependent on strengthening in the public mind the image of Blue Cross as a unique and distinctive public service institution. It follows that the long-range success of the Blue Cross movement is dependent on public acceptance of Blue Cross as a voluntary institution with the same essential characteristics as the voluntary community hospital — nonprofit in character; motivated by broader considerations than self-interest; serving the total community and responsive to the needs of the public, and meriting and receiving broad community support as the source of its strength.

The Blue Cross movement is today at a critical point in its history. As its leaders recognize, two basic problems confront Blue Cross:

1. The Blue Cross position of leadership as the public's preferred method of financing hospital care has been challenged. Competition from commercial insurance is becoming increasingly intense. The public is turning in growing numbers to commercial plans for hospitalization protection. Recent data show that more people are selecting commercial insurance than Blue Cross. Commercial insurance, through such practices as granting preferred rates to select risks, is in a position to attract groups away from Blue Cross which are essential to the stability and success of Blue Cross.

2. The necessity for repeatedly increasing the rates charged for Blue Cross protection is creating public confusion, uncertainty and resistance. The increasing use of hospitals by the public, the increased use of hospital services by patients during hospitalization, and higher standards of hospital care, coupled with the effects of inflation, are continuing to force hospital costs and Blue Cross rates higher.

This memorandum was prepared by an economist in the health field and circulated to members of the Blue Cross Commission by James E. Stuart, Chairman.

judge ourselves, but, in the final analysis, the nonprofit prepayment program will be judged on two points:

1. How well do its benefits meet the needs of the people?

2. What percentage of the population does it serve?

Our efforts to improve our position on those two points have become complicated by changes in the health services themselves and by the increasing activity of commercial insurance companies. Higher costs, greater utilization, and more intensive competition are forces that can either distort and weaken, or shape and strengthen, our program. The outcome depends on our ability to see those forces in their proper perspective, and to deal with them without panic or fear.

The greatest danger to Blue Cross and Blue Shield in these critical years is the growing trend toward solution, or attempted solution, of our problems on a purely local basis without adequate reference to the national point of view. We can dissipate our strength and ultimately lose our identity by trying to go in too many directions at the same time. If that should happen, the individual plans which together represent the Blue Cross and Blue Shield movement in this country soon would disintegrate into a series of semicompetitive, pseudo-insurance organizations. The opportunity to develop as a true national health care program would be lost by default.

We can be led down that path by too great a preoccupation with the methods and the objectives of our stimulating friends, the commercial insurance companies. While we should respect their size, their ability and their success in selling hospital and surgical coverage, we must not confuse our objectives with theirs. Nor can we hope that our own problems will be solved by adopting standard insurance technics and controls. We would be foolish, of course, to say that all insurance procedures are taboo for Blue Cross and Blue Shield; we have used some of them from the beginning and we may find others useful in the future. Insurance companies have learned a great deal from us, and we should not be opposed to learning from them. But it seems to me that our every action must be measured first of all in terms of our larger objectives. If what we do brings us closer to those objectives, then what we do is fitting and proper for Blue Cross and Blue Shield. It is wrong only if it leads us away from those objectives. It is wrong if it is a frightened compromise between what we know we should do and what we think we have to do. If we have been wrong in the past, we must have the courage to recognize our mistakes and the determination to correct them.

However, just as there is no excuse for complacency at this time, there is no justification for undue criticism of what has been done. Both Blue Cross and Blue Shield have gone far toward making the benefits of modern health care available to the American people. If commercial insurance companies have been successful, we are responsible for at least part of that success. We have not failed to make the public conscious of the need for protection against the cost of health care. But we may fail to make ourselves the primary instrument of that protection unless we take time now to reexamine our program in the light of its present direction and probable future. If we have gone astray or if we seem to have departed from original objectives, there still is time to get back on the right road. The question is, how much time do we have?

We changed our character, decisively and for the better, when we took the step that enabled us to extend our local services to meet a national need. Blue Cross and Blue Shield enrollment in the automotive and the steel industries a few short years ago proved that the nonprofit prepayment program could provide for health care on a coast-to-coast basis, with uniform rates and benefits.

That step was followed in other industries and business organizations. Today, management and labor are gaining confidence in our ability to provide maximum hospital, surgical and medical benefits on a national scale with a simplicity and economy not possible in any other program. However, in our

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Realization of the original concept of hospital protection assured on a "service" basis—the principal on which the Blue Cross movement was founded and from which its strength has stemmed—is jeopardized by the pressures for higher rates. Not only do these pressures make it difficult in many instances to maintain present benefit standards, but they substantially slow the rate at which gaps in protection can be closed in order to realize the full potentialities of the Blue Cross idea. Moreover, the evidence points to the conclusion that many of the factors creating pressures for increased rates are not transitory but will continue to be felt in the future.

Reduced to its essentials the question to be decided involves a choice of one of two basic alternatives: Should Blue Cross become in the public mind an organization parallel to and in direct competition with commercial insurance—existing for the same purpose and operating in essentially the same manner as commercial insurance? Or should Blue Cross become in the public mind a community institution so distinctly different in character from commercial insurance that it is essentially removed from competition with it?

If future development follows insurance lines, the public would come to view Blue Cross as one of many prepayment organizations competing for public favor, and points of difference such as sponsorship and legal basis would tend to be overlooked —much as the technical distinctions between mutual and stock companies are now overlooked. Promotion of this image of Blue Cross as a competitive organization would tend to accentuate the pressures pushing Blue Cross in the direction of closer resemblance to commercial insurance with respect to operational policies and practices. The public would consequently expect Blue Cross to meet competition on whatever basis develops. It would expect Blue Cross to adopt experience rating, offer benefit patterns parallel to competitors', including restrictions as well as "appeal" items, and engage in commercial sales approaches involving higher acquisition costs. The public would come to think of Blue Cross as operating in self-interest and substantially discount any statements to the contrary.

The image of Blue Cross as an organization in direct competition with commercial insurance would mean eventual loss of preferential consideration on the part of community leaders and civic organizations. Even hospitals and physicians would find favoring

desire to earn that confidence we have not always followed a clear-cut pattern. The results are sometimes confusing to both labor and management and to ourselves.

We know, from experience, what they like about us: our relationship with hospitals and doctors; our direct, uncomplicated procedures in handling claims; the easy contact with participating plans on a local, community level; our nonprofit method of operation, and our willingness to improve our program whenever possible.

We also know some of the things they don't like about us: our occasional indecision about the method of enrollment; our failure to provide full service benefits in some areas; the reluctance of some plans to take part in the national program, and the possibility that some of us may become instruments of the hospitals or the doctors rather than of the community at large.

Knowing these things, we should be working constantly to improve our national program along the lines that are indicated so clearly. By so doing, we will at the same time improve each individual plan, for the national program can be no stronger than the pillars upon which it rests.

So far as I know, there is no magic formula to guide us in our efforts to tie together the loose threads of our local and national fabric. There is no simple, expedient road to follow. If there were, we would be unwise to follow it because there is no salvation for us in expediency. Our need is for straight thinking — sound, impartial, unselfish thinking followed by equally sound, impartial, unselfish action.

As a starting point, let us face the fact that a considerable amount of confusion and uncertainty exists in our national enrollment activities. There is wide variation also in local plan interpretation of benefit schedules, rates and controls necessary to maintain and expand community enrollment. This isn't surprising. We have grown so fast and our environment has changed so rapidly that a more chaotic situation might have been expected. Such a situation remains a definite possibility, for so much that was conceived in simplicity has become clouded and complex.

We began our national enrollment activities with the realization that only through such a program could we offer our services to those employed by the larger business and industrial organizations. If we had done otherwise, we would have denied Blue Cross and Blue Shield protection to many residents of our own communities. From the very beginning, national enrollment represented an extension of benefits by the local plan to the people of its own area.

To accomplish this, new procedures had to be established. Two basic things were done. An Inter-Plan Enrollment Program, known as the syndicate arrangement, was set up to enable local plans to provide the benefits of a negotiated contract, represented by a headquarters plan in the company's home area. Health Service, Inc., and American Medical Indemnity, Inc., commercial stock insurance companies in structure, were formed to underwrite benefits in those areas where local plans were temporarily unable to handle the program or where a local plan did not exist.

It is important that we clarify our thinking on this subject. On one hand it is argued that Health Service, Inc., and American Medical Indemnity, Inc., do not fit properly into the picture because they are taxable companies and threaten our own tax-free privileges. It is held that this type of enrollment agency creates additional overhead; that it is subject to insurance department restrictions that are not compatible with Blue Cross-Blue Shield operations; that it concentrates too much impersonal authority in a small, central group; that it has overstepped the limits of its original purpose.

On the other hand it is argued that the syndicate program makes it difficult for some plans to participate; that it places too much of a burden on the headquarters plan which is primarily responsible for negotiations and administration; that it complicates the activities of participating local plans which have only a few of the enrolled employes in their areas.

Without extolling the virtues or be-

(*Continued on Page* 136)

Blue Cross difficult, because under such circumstances they could not support one competitor over another. Possible exclusive utilization of Blue Cross by government for coverage of governmental employes or other groups for whom it has, or assumes, responsibility could not be expected.

The other alternative is the development of Blue Cross as a distinctive community institution, essentially different from insurance. In this context the public would view Blue Cross as a public service organization designed and operated to finance hospital care for the people of the community. The public would come to think of Blue Cross as a voluntary organization with the single objective of achieving, on a nonprofit public service basis, whatever is required to meet community needs — needs of people as well as needs of hospitals. The public would think of Blue Cross as the community's own institution, not a commercial organization "selling" for profit. In the public mind Blue Cross would not be considered as in competition with commercial insurance, but would be a different and unrelated kind of organization with a unique rôle and representing voluntary cooperative efforts of the people.

These alternative routes lead in divergent directions. It is not possible to follow both routes simultaneously. If the decision is to meet the commercial insurance challenge by doing the same job on the same basis, with the same technics and practices, but doing it better, it points to modification of Blue Cross programs and methods of operation to meet the specific requirements of day-to-day competition. But if the decision is to meet the commercial insurance challenge by essentially removing Blue Cross from competition —by setting it apart from and above commercial companies—the rôle of Blue Cross becomes a quite different one. This decision dictates the development of community-wide support by accelerated promotion of a public image of Blue Cross as a nonprofit service agency. It means that in program administration and program development the spirit of Blue Cross must be consistently demonstrated to achieve the dignity inherent in its rôle. Thus, gradually but surely, the public would come to think of Blue Cross as a distinctive organization in an entirely different category from insurance companies. Under these circumstances, Blue Cross could, it is conceivable, eventually be out of reach of commercial insurance competition because the public would understand that unlike things were being compared.

Taking a tip from department stores,

Mount Sinai Hospital finds it pays to

Treat the Patient as a Customer

MARTIN R. STEINBERG, M.D.
Director, Mount Sinai Hospital, New York City

LEON JACOBSON
Public Relations Supervisor
Mount Sinai Hospital, New York City

MOUNT SINAI Hospital of New York recently opened a supervised playroom where prenatal patients may leave their children while attending appointments with the hospital doctor. Situated off the clinic's main entrance, well stocked with toys and otherwise made attractive for children of all ages, this resident "baby-sitting" facility is a boon to the hospital as well as to the mothers who use it, for it eliminates the major excuse for absenteeism—what to do with Johnny—and in that way makes a contribution to the efficient operation of the clinic.

The fact that this facility was planned in the initial stages of a new maternity service, despite all of the other problems waiting for solution, attests to the growing acceptance in the hospital of the principle of the customer psychology as a governing factor in our relation with patients and visitors.

Our object in establishing such a facility was, of course, to make it easy for the expectant mothers to come to the clinics. We had a purpose beyond that, however, and perhaps a more important purpose. We hoped to make it apparent to our staff that we wanted these patients to come, that we were putting ourselves out in an effort to attract them, that indeed they were not receivers of charity but our customers. The customer psychology is well advertised and understood in this country of ours. The customer must be catered to and served. His wants must be anticipated. We must "sell" him our services and materials, and we must "sell" him on our establishment.

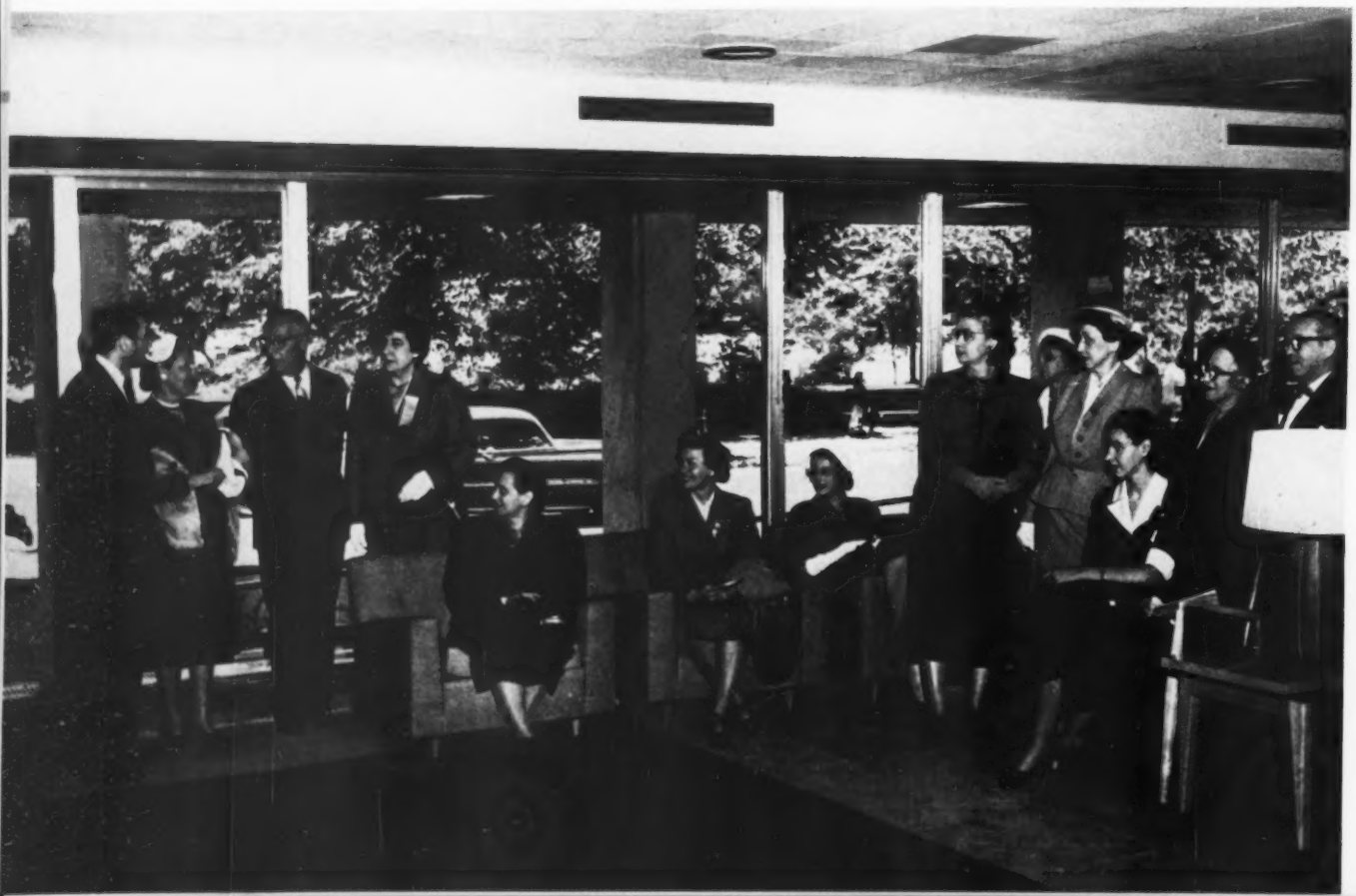
American business, especially the department store, owes much of its success to the customer psychology. The observation of this goes considerably beyond courteous sales manners. There is a constant search for additional comforts, additional services which will attract the customer. It is strange that so often the hospital which performs a service valuable and vital for the patient fails to win his appreciation by treating him always as a patient but not always as a customer. Doctors are provided to look

The small daughter of a prenatal clinic patient at Mount Sinai Hospital happily enters the playroom while Mama goes off for her examination.

after him, nurses and social workers to assist; every care is taken that medicine and meals and hundreds of other details are arranged to do the primary job—curing his illness—and there too often it stops. The comfort of the visitor, the small extra services which would delight the patient and his family and his friends are too often overlooked because they are not essential. But the delight and gratitude of the patient and his family that would flow from these extra attentions would be generated precisely because they are not essential. They are extras. In the minds of our patients (customers wherever else they seek service) the extra comforts and attentions have been well advertised and accepted as the gauge of an establishment's esteem for them.

Above: This outmoded "corridor-type" waiting room was standard in the Twenties and Thirties. Now, fortunately, it is giving way to such handsome and spacious areas as the lounge shown below, in Mount Sinai Hospital's new Magdalene and Charles Klingenstein Maternity Pavilion.

There has been progress in this direction in hospital administration. Comfortable lounges, TV sets and attention to decor, extra facilities to accommodate visitors — these are all evidences of the growing acceptance of the customer psychology. Most of them have been observed in the area of the private patient and perhaps the semiprivate patient relationship. Even in these areas, we have much to learn from the hotel and the department store. Let us consider for a moment the introduction of the patient to his room. Many hospitals do now issue a booklet or pamphlet telling the patient how much care has been taken to see that his illness is cured. I think, however, we are missing some effective, relatively inexpensive gestures, for instance, a notice telling the name of the housekeeper who has prepared the room, and checking off a dozen or two details which were looked into to assure sanitation and comfort. The patient often wonders who occupied the room before he came and what dread illness preceded him. The hotel takes this into account. It wraps his drinking



The children's waiting room situated off the clinic's main entrance is well stocked with toys and otherwise made attractive for youngsters.

glass in cellophane and the toilet seat is encased in a paper band which makes it "sanitized," and so forth.

It is in the wards and in the outpatient department that the customer principle is almost entirely neglected, and yet a great deal of our appeal to the community is on the basis of our service to those patients. Even when we consider the problem purely from the financial side, we need the ward and clinic patient, for once we have established these facilities, the unused bed and clinic appointment are the most expensive ones to the hospital.

The installation of the baby-sitting area came as part of our attempt to use the customer psychology in the clinics and in the wards. The appeal to the staff for courtesy and consideration in the reception and management of our clinic patients had a good but a limited effect. On the whole, these patients are perhaps more difficult to deal with. They are considerably more on the defensive and are likely therefore to be demanding. They expect to be treated as seekers of charity and are inclined to interpret acts as lack of attention when they are not intended as such. Frequently, they may not be able to express themeslves too clearly. Partly because of the extra patience required, we found that employes who served well in the private pavilion, say, did not necessarily work out in the outpatient department. We needed more than an appeal for courtesy. We had to impress the staff with the fact that we valued highly the clinic patient, that we wanted him to come, that our entire reason for existence and the entire reason for the employment of the staff in that area was to encourage the clinic patient to come and to be served.

The improvement of physical facilities, we felt, would be the next step in the program. Our outpatient building and annex were built some 30 years ago when the hospital's 35 clinics were accommodating some 400 persons a day. The same physical plant with a few minor improvisations holds 90-odd clinics today and accommodates between 900 to 1000 persons daily. Apart from the main OPD reception lounge, the corridors separating the clinics serve as waiting areas. We have been trying to improve that situation. We converted one of these waiting areas which served the psychiatric clinic into a separate waiting room that has the quiet, comfortable and friendly air of a doctor's reception room. The floor was covered with rubber tile. Sofas were strategically placed and flanked by end tables holding lamps for soft lighting. The walls were paneled and covered with attractive wallpaper. The ceiling was treated acoustically. This room has become our model. We hope to make all waiting areas look like it. In the meantime, we regularly seek to improve other areas by the application of paint, the renewal of furniture, better lighting, and an occasional flower box.

We have found that the attitude of the clinic worker toward the patient is immediately improved when we have created a more comfortable place to work, but that the extra dividend comes from the impression of the staff that the patient is the "customer." Our efforts in this direction have really just begun. It is difficult to be certain of the results. There are, however, some perceptible indications that patients are beginning to appreciate the change. We have received, for example, a greater number of unsolicited letters thanking us for specific assistance and praising the hospital. We are hoping that the prevalent attitude of the staff will soon get to be "How much can we do for you?"—for that is the objective of the customer principle.

Mr. Irwin discusses a ledger with Mary J Mansfield, operator of the accounting machine around which the accounting system has been devised.

MECHANICAL ACCOUNTING

maintains efficiency at a high level and reduces costs to a low level

JAMES H. IRWIN
Administrator
Goddard Hospital, Inc., Brockton, Mass.

ABOUT two years ago, the physician-owners of the 65 bed Goddard Hospital at Brockton, Mass., presented the people of the community the land on which to establish a new 136 bed hospital—the Goddard Memorial—to be run by a nonprofit corporation of lay control. As part of the program, the doctors undertook to construct a complete modern clinic.

The people of Brockton and the surrounding areas wholeheartedly assumed their responsibility in the venture and agreed to raise $1,000,000 for the new hospital building. Considerable and highly favorable publicity was given to the venture, generally centering on the theme of people and doctors teaming up to give Brockton "big city" medical care.

This "big city" care has involved myriad problems. One phase of the planning was concerned with the establishment of an accounting system which would meet the hospital's existing needs most efficiently and which would provide a nucleus for handling the figure work involved when the Goddard Memorial is completed.

Our former accounting procedures were entirely manual. An analysis revealed these methods were tedious, slow and expensive in our current operations and would be out of the question for the enlarged organization we were planning. We sought a completely mechanized system with resultant speed and accuracy, and one which would require a modest investment.

In January 1951, the board of directors approved a system which had been developed and which centered on the operations of an accounting machine designed for hospitals. Within a few months, we began to work into our new methods. For another few months, there were wrinkles to be ironed out as the machine and system were brought into synchronization. Since then, the value of the system

has proved itself over and over, particularly on accounts receivable and pay-roll work. We estimate in these activities alone the machine will have paid for itself within a short period, and we expect to get many more years of service from it.

Under our manual procedures, the work on accounts receivable was not sufficient in detail to afford good management control. Now, one girl operating the machine posts every account daily, and all ledgers contain up-to-date information.

Our greatest test came when the Goddard Clinic was organized and began to function. Our volume of accounting work doubled, and we soon were running about 3000 open accounts each month. The new system, however, absorbed the work, with the machine printing an original statement and ledger and producing a proof journal as a by-product of the posting operation.

The mediums for posting are medical services cards which had been mechanically addressed when the patient was admitted. Upon admission, a patient's ledger, statement and medical records also are addressed mechanically.

The same form of cash ticket is used for clinic and hospital patients, whereas each organization has its individual charge ticket.

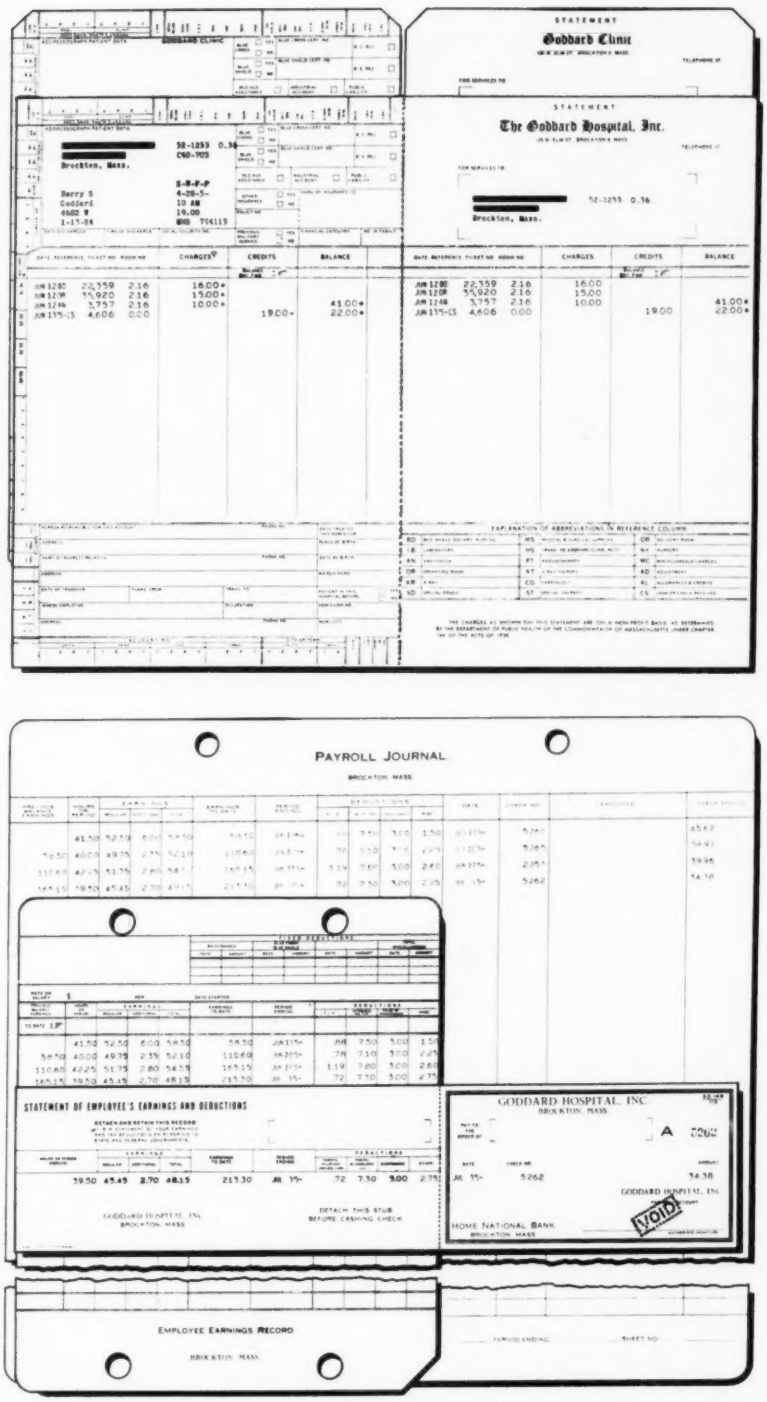
For the clinic, a statement is sent to each patient at the end of the month, regardless of whether services have been completed. Hospital patients receive statements upon release.

When the accounts receivable run has been completed, the posting mediums and proof journal are forwarded to the statistical department where they are posted to the daily summary sheet.

Preparing the pay roll, which formerly involved work loads and overtime, is now handled smoothly and rapidly, for 145 employes in the hospital and for 35 in the clinic.

An employe's statement of earnings, pay check, and the pay-roll journal are computed and printed in one simple operation on the machine, as are the employe's earnings records for governmental and tax reports.

In brief, our new system has enabled the trial balance, age analysis, accounts receivable, and all of our accounting records to be completed on the second working day of the month. It fills our requirements of today and has proved that it will meet the requirements of the Goddard Memorial.



Top: On accounts receivable, the patient's ledger, statement and a proof journal are prepared simultaneously. Below: When the pay roll is prepared, the employe's earnings statement, pay check, earnings record, and the pay-roll journal are completed in one operation.

The basis of a hospital's budget is the expected revenue for the services rendered. The fulfillment of these services involves considerable work, detail and expense, including all necessary accounting work. A hospital office cannot produce revenue, but through efficient operations it can help hold costs at a low level and maintain services at a high level.

Eisenhower Proposes Federal Aid for Health

"Reinsurance" for voluntary prepayment plans, aid for construction of long-term and outpatient facilities, expansion of rehabilitation program are main features

WASHINGTON, D.C. — Federal assistance to broaden voluntary hospital and medical prepayment coverage, expansion of the Hill-Burton program with emphasis on facilities for long-term illness and outpatient diagnostic centers, and a program for rehabilitation of disabled and handicapped persons were the principal elements in the national health plan proposed by President Eisenhower in his special health message to the Congress January 18.

The President proposed:

1. Establishment of a federal reinsurance service for private and nonprofit health insurance organizations, enabling them to offer broader health protection to more families. Under this plan, which would be launched with a $25,000,000 fund, private and nonprofit prepayment health plans would pay a small percentage of their premium income as a fee for reinsurance against major losses.

2. Additional federal assistance in the construction of nonprofit hospitals for care of the chronically ill; nonprofit, medically supervised nursing and convalescent homes; rehabilitation facilities for the disabled, and diagnostic or treatment centers for patients not requiring bed care.

3. Progressive expansion of the program for rehabilitation of the disabled, using federal and state funds, aimed at reaching a goal of 200,000 rehabilitated persons annually by 1959.

Following release of the President's statement, the American Hospital Association's Washington Bureau praised its "sound extension of the Hill-Burton Act" and "endorsement of voluntary prepayment as the soundest method of meeting the cost of adequate hospital care," but declined to comment on the reinsurance proposal pending study of specific legislation.

Also declining comment was the American Medical Association. However, A.M.A. President E. J. McCormick of Toledo said private health insurance companies were doing an adequate job without necessity for government help. Dr. McCormick said the A.M.A. would hold a special conference in Chicago to study the proposals in detail.

In presenting his program to Congress, the President stood squarely on the principle that medical care should be available on an equal basis to the whole population. "The means for achieving good health should be accessible to all," he declared. "A person's location, occupation, age, race, creed or financial status should not bar him from enjoying this access."

Nevertheless, the President specifically rejected plans that would socialize the medical profession. "Freedom, consent and individual responsibility are fundamental to our system," he explained. "In the field of medical care, this means that the traditional relationship of the physician and his patient, and the right of the individual to elect freely the manner of his care in illness, must be preserved. In adhering to this principle, and rejecting the socialization of medicine, we can still confidently commit ourselves to certain national health goals."

In calling for a reinsurance plan to bolster private and nonprofit prepayment programs, the President said progress already made in the development of voluntary prepayment plans

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House Committee Hears Experts in Hearings on Health Bills

WASHINGTON, D.C. — Health insurance that "chisels" policyholders in fine-print provisions excluding coverage of major medical expenses were condemned here last month by Dr. Paul Magnuson, former medical director of the Veterans Administration and chairman of President Truman's commission on the nation's health.

Testifying before the House commerce committee, which is conducting hearings on health insurance bills introduced by its chairman, Charles A. Wolverton of New Jersey, Dr. Magnuson said it is the big medical expenses that "break the back of the average wage earner," yet these major expenses are often excluded from health insurance contracts.

Dr. Magnuson said he favored a federal reinsurance program for voluntary prepayment hospital and medical plans, as described in President Eisenhower's health message to the Congress and provided for in one of the bills introduced by Rep. Wolverton. The reinsurance program, which would set up a federal insurance agency to underwrite "excess liabilities" for participating prepayment plans, would "permit the private and nonprofit insurance companies to offer broader protection to more of the many families which want and should have it," Dr. Magnuson said. Under such a system, he added, prepayment plans would be able to extend their services and still be protected from financial catastrophe.

Other bills introduced by Rep. Wolverton would provide federal funds for insuring loans to hospitals, clinics, health centers, doctors' offices and other health facilities for construction and equipment; and amend the present income tax law to permit deduction of premiums paid for health prepayment plans up to $100 a year.

Testifying before the same committee, another member of the former President's commission on the nation's health needs, Al Hayes, president of the International Association of Machinists, outlined a "minimum program" for health, including federal grants to medical and nursing schools, expansion of Hill-Burton aid for hos-

(*Continued on Page* 168)

How to Make Group Decisions Decisive

EDMUND MOTTERSHEAD
Mottershead Associates, Chicago

AN INCREASING amount of institutional business today is being conducted through group meetings of boards of directors, staff committees or special groups of executives and workers, all for the purpose of considering a particular problem. In these situations many experienced executives face some difficulty, if for no other reason than their lack of specific experience in speaking before groups and in handling group situations.

However, the problem of presenting an idea to a group or committee is not entirely solved by ability as a speaker, by knowledge of what one has to offer, or by self-confidence, polish and preparation. To a large extent, group leadership becomes effective only when the specific aspects of the group situation are considered and when certain technics for leading group discussion and bringing about group decisions are used.

There are several special factors in handling groups which tend to make it easier for either an individual member of the group or the group chairman to lead discussion. One of the most commonly overlooked is the seating plan for the conference.

In Figure 1 are shown two of the commonest and normally most successful arrangements. These seating arrangements accomplish two things. They allow the members of the group to see one another so that the talking is more conversational, and they also establish a balanced relationship between the discussion leader and the individual who is acting as secretary and taking notes.

There is a strong psychological effect in having a stable personality located in a key spot in a group. The emotional effect of this personality, coupled with the general knowledge that this individual is likely to cooperate with the discussion leader, tends to hold the other members "in line" and "in order."

The problem of handling groups of people is much the same whether they are gathered around you in a meeting or working with you in an organization. Apart from all rules or procedure and plans for meetings and orders of business, there are a few basic things you should keep in mind when handling groups:

1. Stay level-headed. Group psychology demands a leader who will stay on an even keel and remain master of the situation, unruffled regardless of what happens.

2. Have a plan. By and large, people do not think any more than they have to. Hence, he who has a plan almost automatically winds up successfully whether he starts as chairman of the meeting or merely as a member participating in the regular fashion.

3. Stick to the plan. The maintenance of the discipline inherent in any plan makes for stability in people. People want to know where they stand, where they are going, what is going to happen next.

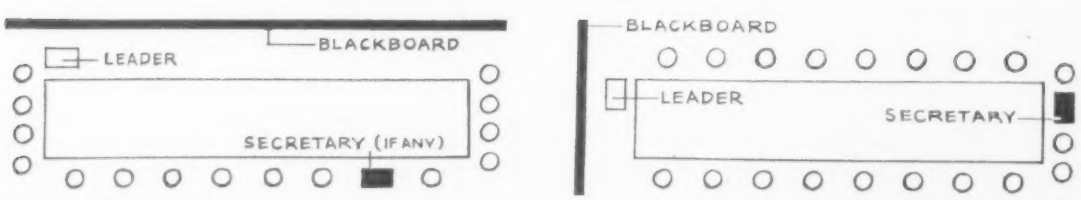
4. Be positive. Most people cannot differentiate between affirmation and proof. But, they can tell when you have confidence or not, and they follow confidence and shy away from hesitation or what looks like indecision.

5. Provide direction unobtrusively. When you are bringing in any new policy or new program for discussion in a group meeting or when trying to put it across among other people around you, lead into it gently. There are two technics which will help the group make right decisions: One is to state the problem; then get them to restate the problem. Suggest that they come up with a solution, and jockey back and forth until someone comes up with the answer you want.

The other method is to get a member of the group to bring out your ideas for you. This can be done directly by having one man agree to help beforehand, or it can be done indirectly by discussion with one or two people beforehand so that they bring up the suggestions you want without being conscious that you planted the seed.

Getting any group decision is basically more difficult and more complicated than is getting a decision from

Fig. 1: Diagrams of possible seating plans for conferences.



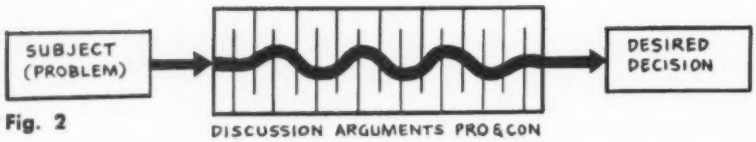


Fig. 2

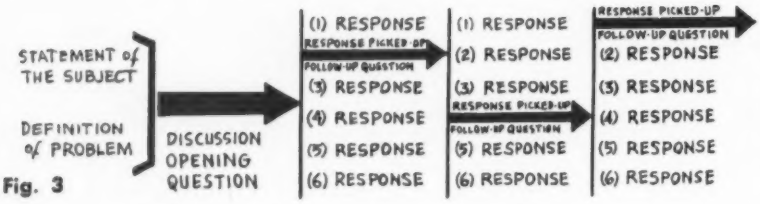


Fig. 3

Fig. 2: The problem is to guide discussions through arguments to a decision. Fig. 3: The technic is to ask a leading question, pick up one response which follows the leader's thought as a follow-up question, and continue in this way until desired decision is made.

one individual. With a single person a direct conversational method usually yields a firm meeting of minds, and mutual understanding is reached in a relatively short time.

In contrast, the members of a group may not have the same background; the same approach to their particular problem or need at the moment; the same degree of understanding of institutional problems; the same amount of intelligence or quickness of response, or the same emotional makeup. The men and women in the particular group to which you may be presenting your ideas come together for a variety of reasons, and their participation in any discussion springs from equally divergent bases. These elements of individual background plus individual differences in personality and temperament combined may make large demands on anyone attempting to bring about a decision from the group.

6. Don't make a speech. The first principle to observe in leading group discussion is *not* to make a speech and then sit down and let the members of the group chew it over among themselves. That is what the group would ordinarily expect, and it is the method commonly used—by reason of which a great deal of time is lost and idle discussion is indulged in without any decisions being reached.

After all, once you have made your presentation and told your basic story, it is from the discussions of the members of the group that the decision will come. Your basic strategy, then, is to rough out your ideas and start discussion, acting more or less as the discussion leader in guiding the group's thinking and talking about the problem. As the little diagram in Figure 2 indicates, your problem is to guide the discussion through arguments and disagreements to a decision. As shown in Figure 3, this technic is revealed as being one of asking a leading question and waiting for a number of responses from the group, and then picking up one of the responses which follows your line of thought as the basis for a follow-up question.

Wait for a few more responses to this second question; select the next response which is "going in the right direction" and ask another follow-up question.

By repeating the process, you not only allow members of the group to express divergent ideas and avoid any feeling that you are bottling them up, but at the same time you are drawing from the group ideas and facts which are necessary to arrive at a decision. In effect, you guide the group into "selling themselves."

Avoid any arbitrary or obvious pattern of picking out the responses you use in your leading questions and follow-up questions. Sometimes the response you want may be the first one you get; sometimes it may be the last of several responses. Vary your strategy a bit instead of seizing upon the response you want immediately, so that you are not obvious in guiding the discussion. Remember that you are not arguing with the group—rather,

NINE STEPS TO A SUCCESSFUL CONFERENCE

EACH conference should have a definite objective. The leader or chairman must keep this purpose clearly in mind as he plans the conference through the nine steps outlined. He must constantly check his progress during the meeting against that outline. He needs a plan, an outline and a timetable. The nine steps followed in the orderly and effective handling of a discussion meeting are:

1. *State the specific subject* of the conference clearly and concisely. Make it relevant to current institutional problems.

2. *Open the subject.* In introductory remarks by the conference leader there should be some explanation of the subject, outline of things to be considered in the meeting, questions that will be raised.

3. *Define terms.* Draw out from the group a definition of the subject; establish a definition of terms that will be used in discussing it. Check with participants at all times to be sure there is unanimity of understanding and acceptance of terms. Use a blackboard if convenient.

4. *Get facts and data from the group.* This is the major stage of discussion where the subject matter becomes applicable to immediate problems in each man's department. A number of devices are effective: a pro-and-con analysis may be used to bring out the advantages and disadvantages of a given course of action; a cause-and-effect analysis or a ways-and-means analysis will bring out different points; these may be used separately or in conjunction with the first method.

Other types of analysis used in developing facts and data from the group include a factor-comparison method in which factors of difference and similarity are brought out; a responsibility and lines of authority analysis, and a qualifications or requirements analysis. All of this material is drawn from the experience and current problems of group members.

5. *Selection of facts and data* to be used in reaching conclusions. Data obtained, usually noted on blackboard, are checked by group discussion against the basic purpose of the session. Basic question is: "Does this fact or element contribute to the purpose of this discussion?" For

you are on the same side of the fence with it, working out a solution to your mutual problem.

7. Handle objections *tactfully*. Every discussion leader encounters resistance to his ideas. Sometimes these objections are real, but much of the time they are imaginary. We should not go so far as to say that people give false reasons to support their objections, but many of their objections are not valid, while their real reasons, often unconscious, lie hidden.

Every institutional executive has encountered resistance from employes and customers in the form of countless complaints, small grumblings, fault finding, disobedience and excuses.

To a certain extent, these resistances are real; to a large extent they are founded upon misconceptions owing to a lack of information which may be the fault of the executive himself. However, real or false, these objections are valid in the mind of the individual who voices them and must be treated as such.

The real problem is not the validity or the honesty of the objections, but rather what to do about them. They must be met and overcome in such a way that they are removed, not merely beaten down to rise again later on. They must be met and overcome in such a way that the listener is hardly aware of what is going on except that he has somehow changed his mind voluntarily. There are several technics in common use for overcoming objections. Among them are:

1. Direct rebuttal. In plain language, "you're wrong!" The man who shouts the loudest wins that round. The old jingle says: "A man convinced against his will is of the same opinion still." You can browbeat a buyer or a worker into action, but you cannot change his mind that way. Go back to first principles. The big secret in dealing with people is to make them *want* to act as you wish.

2. "Yes . . . but." This is a little more tactful, and is perhaps oftenest used by people who are making a conscious (and often obvious) effort to be "tactful." In essence: "There is no doubt a lot of truth in what you say, Mr. Jones, and you undoubtedly have given the matter a lot of thought, but here is a factor which you perhaps have not considered, and because of it you should do so-and-so."

3. Boomerang, or finding a way to turn the other person's argument in your favor. This is the method that really rings the bell, but you are required to be constantly alert to use it. The fellow who doesn't want to buy accident insurance because he had seven narrow escapes last year and says he's lucky . . that's just the reason he should buy it. It happened to Tom Smith down the street, and the law of averages makes it this man's turn next.

The same technics of overcoming objections may be used effectively in all types of group discussions. The direct rebuttal usually arouses personal animosity and anger, and must be done with extreme caution and in a very obviously friendly fashion. The "Yes . . . but" method is usually the easiest to employ in conference or committee work, because it gives you a chance to acknowledge the sincerity of purpose, honesty and good intentions of the other person and still support your own contention. The boomerang method is still the most powerful of the three, but must be used with caution in group meeting, because the diversity of many minds simply means that not all persons will realize as rapidly the truth of what you are saying, but will instead react emotionally against an attack on their own ideas.

Both for the chairman and the individual group member, it is a good habit to take a few notes during the session of what is being said.

Frequently, a highly effective contribution can be made to discussion when you have a chance to get up and say, "A while ago Mr. Blank brought out this idea," and go on to repeat the gist of what the other member had said and then indicate how that comment fits into the present discussion. This device has a number of points in its favor. To begin with, it is flattering to the other individual that someone would remember what he said for that length of time. Second, it makes it possible to bring that comment to the attention of the group at a time when it may be most effective. Frequently, members make comments or a contribution to the discussion which get lost that would have been quite effective if made at a different time. Finally, this device aids in leading discussion toward an effective conclusion, should the conference leader or the speaker from the floor desire that the group reach such a conclusion.

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example, in a meeting devoted to considering ways and means of reducing waste, the basic test of data would be "Will this item help reduce waste, and specifically—how?" The bulk of the responsibility for this selection, of course, rests upon the discussion leader, but the final result will develop as the product of the joint effort of the group.

6. *Evaluation of facts selected.* This is commonly done by listing them in order of importance, and offers a further opportunity to narrow the group's thinking into specific channels which can bring about some useful conclusions.

7. *Arriving at a group decision or conclusion . . .* by the group . . . as to the best solution to the problem, the best general policy to adopt on the subject discussed. Build from the statements and recommendations of the members of the group. Remember that the primary purpose of such a meeting is educational, for mutual understanding. It is important that the chairman make sure that each member of the group understands and appreciates the final conclusion and sees how it may be applied in his own department.

8. *Planning to make the conclusion effective . . .* developing from the suggestions of the group a plan that will be workable as a means of implementing the policy or action agreed upon. This may be done by a ways-and-means analysis through committee action, or other means.

9. *Summarizing the conference.* In addition to the final summary by the conference leader or chairman at the end of the conference, occasional but not too frequent summaries by the leader during the conference discussion are helpful in pointing out progress in discussion, the "where we are going and where we are" idea. The final summary should review briefly the purpose of the meeting, highlight the discussion and point out how the final conclusions fulfilled the purpose set for the meeting.

The basic value of the conference method lies in the fact that when a group of executives has sat down together and thought through a mutual problem, and the members of the group have reached a conclusion in their own minds by mutual agreement, they will naturally do a better job of carrying out the responsibilities which that conclusion entails.

Small Hospital Forum

There Is No Excuse for Poor Medical Records

BETTY W. McNABB, R.R.L.
Department of Medical Records, Phoebe Putney Memorial Hospital, Albany, Ga.

BEFORE discussing medical records in small hospitals I would like to establish a basic premise, to wit, there is no difference between a patient in a two-bed hospital and one in a 2000 bed institution. The medical record for both should fulfill the same purposes—it should be of benefit to the patient now and/or later; it should be useful for statistical studies, legal protection of the hospital and all individuals concerned, and research. Consequently, there are only incidental and quantitative differences between medical records in big hospitals and those in little ones.

MUST MEET STANDARDS

We all realize that records in teaching hospitals are detailed and voluminous for many reasons; it is obviously impossible to expect this type of record from a busy general practitioner in a small rural hospital who is carrying a heavy patient load and a big house and office practice besides. But quality must be there, regardless of the institutional source from which the record stems. We know the record must contain "sufficient data written in sequence of events to justify the diagnosis and warrant the treatment and end results," these data to be developed under an established minimum standard originally set forth by the American College of Surgeons and continued by the Joint Commission on Accreditation of Hospitals:

"That accurate and complete medical records be written for all patients and filed in an accessible manner in the hospital, to include identification data; complaint; personal and family history; history of present illness; physical examination; special examinations such as consultations, clinical laboratory, x-ray, and other; provisional or working diagnosis; surgical or medical treatment; gross and microscopic pathological findings; progress notes; final diagnosis; condition on discharge; follow-up, and, in case of death, autopsy findings."

We have seen that these standards will not be lowered; they will in fact be more rigidly enforced, and hospitals more frequently checked, under the new joint accreditation commission, than they were under the overworked American College of Surgeons, which for 34 long years struggled single-handed to enforce professional standards. The commission should be a great aid in obtaining good medical records in small hospitals, and will help eliminate the current statements so often heard from doctors that "we do all we can in this internless institution, don't demand a lot of paper work, too—" and particularly, I think it will quell the uncooperative individual who says: "Why should *I*, an internist [or ophthalmologist, urologist, or whatever he is other than a surgeon] be told by the A.C.S. what I can or cannot do? I don't care whether the A.C.S. approves of me or not—my conscience is clear."

It will be a doughty doctor and a witless institution that will buck the joint commission.

To obtain good medical records in a small hospital, the following combination of qualities, attitudes and tools is considered to be essential:

First: Absolute determination on the part of the governing board that a part of the service offered by the hospital will be good medical records. Collaterally, an understanding by said governing board as to what constitutes a good medical record, and a contingent willingness to provide certain tools, *i.e.* sufficient human and mechanical assistance to the medical staff that it will have no adequate excuse for not preparing good medical records, and insistence by written, enforcible hospital regulation that adequate records be written if staff members admit patients to the hospital. This last corollary on the privilege of admitting patients is difficult for the board to accept in the face of possible existing competition, and in the face of the uncertainties of lay people, particularly newly constituted authorities, when confronted by the purple-hued reaction of a revered doctor who has been informed he cannot admit patients.

LET THE STAFF MAKE THE RULE

It works in many places, however, and is being accepted as the only absolutely impartial, mechanical method for eliminating the incomplete records problem. There need be no personalities involved, no disciplinary action, no running to chief of staff or administrator. When the chart stack gets outside permissible limits, the medical record librarian notifies the admitting clerk, the delinquent staff member already having been adequately and repeatedly notified. The admitting office then politely informs the doctor that he has no bed-space because of incomplete records. He usually screams and orates, then comes in and does

Adapted from a paper presented at the Carolinas-Virginias Hospital Conference, Roanoke, Va., 1952.

A few frank words from a record librarian on the failings of doctors and hospital administrators in regard to their responsibility for medical records

them and that is that. The proven method for success with this no-admit system is to have the rule inaugurated and passed by the *medical staff* itself as part of *its* by-laws.

There is no excuse for allowing unsound records practices to exist because the hospital is new, or because it is old, or busy, or for any other reason. Good medical records are as much a part of good hospital practice as good anesthesia is. The fact that anesthesia brings in money and medical records don't does not excuse the hospital from insisting on the latter as well as the former. The hospital has the same responsibility toward the patient that the doctor has. Just because the medical man sees fit to neglect part of his moral and professional obligation to the patient—the medical record—is no reason the hospital can fall in line.

The patient would actually have a right to refuse to pay if he were in a position to know his record was incomplete, for a complete medical record is due him as a portion of his hospitalization; if he does not get it, the hospital cannot ease out from under by saying "The doctor didn't write it." It is up to the hospital to *see* that the doctor writes it, just as the hospital must see that he scrubs the required number of minutes in surgery.

If the attending physician should suddenly expire or become entirely inaccessible, and the patient needs further study, that undictated medical record won't complete itself, and the patient may suffer. Many a victim (and we use the word advisedly) has been opened up again uselessly because some careless man either didn't tell, or didn't bother to write down, what had gone before. Who has the right to put five minutes' inconvenience against a human life? Or a loss of a half-hour of fishing time, above the danger, distress and expense of major surgery? Yet the simple fact exists — the problem of incomplete medical records is and always has been one of the greatest existing stumbling blocks to good patient care, accurate statistics, contributory research. This is, beyond a doubt, the joint responsibility of medical men who won't write records, and hospital authorities who won't put on pressure.

RECORDS COMMITTEE ESSENTIAL

Even if the by-laws of the hospital insist, on penalty of suspension, that complete medical records be written, and the hospital authority makes this regulation stick, the real help with medical records, if quality is to be ensured, must come from the medical staff. The most valuable asset the M.R.L. can have is a functioning, energetic, conscientious, impersonal medical records committee of the staff, cognizant of the value of medical records, willing to keep the other doctors in line, come what may, and able to do it through policing of the medical staff *by themselves.*

Another rapidly developing aid to the quality of records, emanating from the medical side, from which all control of records quality should emanate, is the medical audit (provided it is used in the manner for which it was originally planned). By the audit, the groundwork for which is laid by the M.R.L., the staff receives a complete critique of its performance, the administration gains a thorough picture of the level of professional work being done in the hospital, the individual is informed in detail of the caliber of his work. It is a potentially dangerous tool, however, if misused.

The American Association of Medical Record Librarians itself is doing all it can, by means of more formal schools, institutes, training courses, the elevation of professional standards in an effort to gain professional stature, the encouragement of meetings with educational and professional programs, to supply the demand for M.R.L.'s—the "human assistance" element. As individual M.R.L.'s we need to sell our profession: to publicize the interesting aspects, to eliminate as rapidly as possible its weak points, to insist that our salary level attain that of other department heads, to recruit young people of high caliber into our ranks, to strengthen our place in the hospital family by making ourselves truly indispensable.

Our rôle should not be entirely that of a suppliant, however. We should approach a new job just as our prospective employer approaches us: he asks for references, educational qualifications, experience, personal background. We might ask him if he intends to back us in our efforts to do our part: if his staff record committee actually functions, if his hospital is accredited or expects to be and is working toward accreditation, if he has good physical equipment or will get it for us. When an M.R.L. takes a position, if the medical records have been and continue to be poor, it is her professional reputation and her future that will suffer. Furthermore, without the cooperation she should have, her life will be miserable anyway. Bullying, heckling, pleading, nagging are not in keeping with the dignity of our profession, nor can the M.R.L. use any tone of authority. She can say "Will you?" but she can *never* say "You *will.*"

A hospital trying to achieve accreditation may certainly explain that its records at present are poor, but that, with the help of a qualified record librarian, it hopes to improve—but it should make good by cooperating with her. Where pay is poor, relations with doctors are unpleasant, equipment is inferior, and general attitude is lackadaisical, nurses, anesthetists, technicians and dietitians depart as fast as they come.

Yet oddly enough, many a hospital is run with these sad characteristics apparent *only* in relation to the depart-

ment of medical records, perhaps because it is an unwelcome step-child in a changing world, of which Charles E. Wilson, president of General Motors, has said: "Every activity in this modern age must be helped on its way by a piece of paper." And there lives no man who wants to sit down and write this piece of paper when he could be doing something more interesting.

THEY ARE NOT ALL BLIND

Fortunately, all medical men are not blind as to the value of records. Dr. David E. Booker said, with tongue in cheek, we hope, that medical records fall in the same class, as far as doctors are concerned, as socialized medicine and income tax returns. Faced by such a statement, one wonders why any of us is foolish enough to venture into the field, or remain in such an atmosphere of tender welcome. Yet his brilliant analysis of "The Physicians' Responsibility for the Medical Record" makes us all wish we had a few more Dr. Bookers on our side; we think the article should be required reading for every medical staff.

Incidentally, why should medical staffs *not* be subjected to a little medical records education now and then? Conscientious doctors devour everything they can read in their own specialties, and medical records should be a specialty of every doctor. Why not ask them to devote one county medical society program each year to medical records? There could be a review of currently used hospital forms, with constructive criticism and suggestion, a refresher on standard nomenclature, written for and by doctors but used mostly by record librarians who frequently know not what they diagnose; there could be a paper on the doctor's part in writing records, and a recapitulation of the minimum standards and the staff by-laws on records which each doctor signed when he was admitted to the staff.

Everywhere we hear that the medical record librarian is part of the team —the medical record is part of the patient's treatment. These are the tunes we must sing to administration and staff—these are the themes on which we must elaborate if we would receive the recognition our pride in profession demands, if we would receive the cooperation our exacting job must have to give usable, valuable results.

In the small hospital, the medical record librarian is far more than the "custodian" of the record; she is the statistician who furnishes local, state, regional, and national agencies with the data from which they draw policy-making conclusions; she is the liaison between a thousand questioners (all of whom, she must *know,* not guess, are legally entitled to the answers), and the medical staff, patient, nurse, hospital. She is the individual whose responsibility it is to be sure the medical record is legally protective to doctor, patient, hospital; she is the agent who collects and coordinates data flowing into the record room from every hospital department, and who tactfully corrects deficiencies and errors spotted by her trained mind, and still maintains peaceful relationships with everybody concerned; she is the individual who assembles the information required at intervals by administrator, board and auditor; she is the person who assists the doctor at his painstaking research, staff programs, group studies, medical audit. She is, in short, a person of many grave responsibilities and numerous exacting duties, and she has become indispensable to the proper practice of medicine and to the proper operation of a qualified modern hospital.

WHAT "M.R.L." MEANS

This draws a highly ambitious picture of the medical records librarian —yet it is actually these skills and abilities which we infer that we possess when we sign M.R.L. or R.R.L. after our names. We think the administrator should have his innings, too. We expect him to improve our lot if it needs improving—he should expect us to do the same for him. He can trade book-learning for experience; as we acquire experience in his hospital, he can insist that we augment it by studying the texts written for us by the experts in our field. If we can say to him, "I won't work for you unless you will follow through on improving our department—" he can say to us, "I won't hire *you* unless you will follow through on improving your professional knowledge." The inexperienced, untrained clerk cannot learn the complexities of our profession in an eight-hour day. She must study, and study hard.

Then the administrator will see to it that his record librarian attends institutes and meetings, and has the books she needs. He may avail himself of group supervision, another material aid in the achievement of good medical records for small hospitals. While it is not a brand new trend, inasmuch as many M.R.L.'s have been doing group supervising on their own for years, the widening recognition of this type of medical records practice has led to the formation of an A.A.M.R.L. committee for its study. From this it is hoped (1) that a definite program of group supervision will develop, with stated qualifications, contractual schedules, designated duties, and established teaching criteria; (2) that group supervisors will be available for short or long-term supervision of reorganization of medical records departments, and (3) that, eventually, in return for cooperation from administration and medical staff in requiring and preparing good medical records, the hospitals will be assured of well qualified personnel and the doctors will receive adequate assistance as they discharge their responsibilities in regard to records.

LISTS FOUR ESSENTIALS

In summary, there are many things which will improve the caliber of medical records in small hospitals; all are available if the hospitals themselves want them badly enough. To assure good records we must have:

1. A respect for, and desire to abide by, minimum standards; a sincere wish to be accredited in an effort to assure better patient care through better procedures in every department.

2. Willingness on the part of administration and authority to achieve good medical records by insisting that the medical staff write them; by providing adequate physical equipment, suitable salary, and cooperation to the medical record librarian, by insisting on trained medical records personnel or personnel willing to undertake self-education through written aids, institutes and other training facilities.

3. Education of the medical profession itself as to the value of medical records, their absolute and vital importance to the patient's welfare, statistics, evaluation of hospital and individual performance, and research.

4. Ceaseless efforts on the part of M.R.L.'s already in the field to educate themselves still further, to make themselves more valuable to their institutions, to publicize their profession, to recruit newcomers, and to improve the quality of their service by such developments as group supervision.

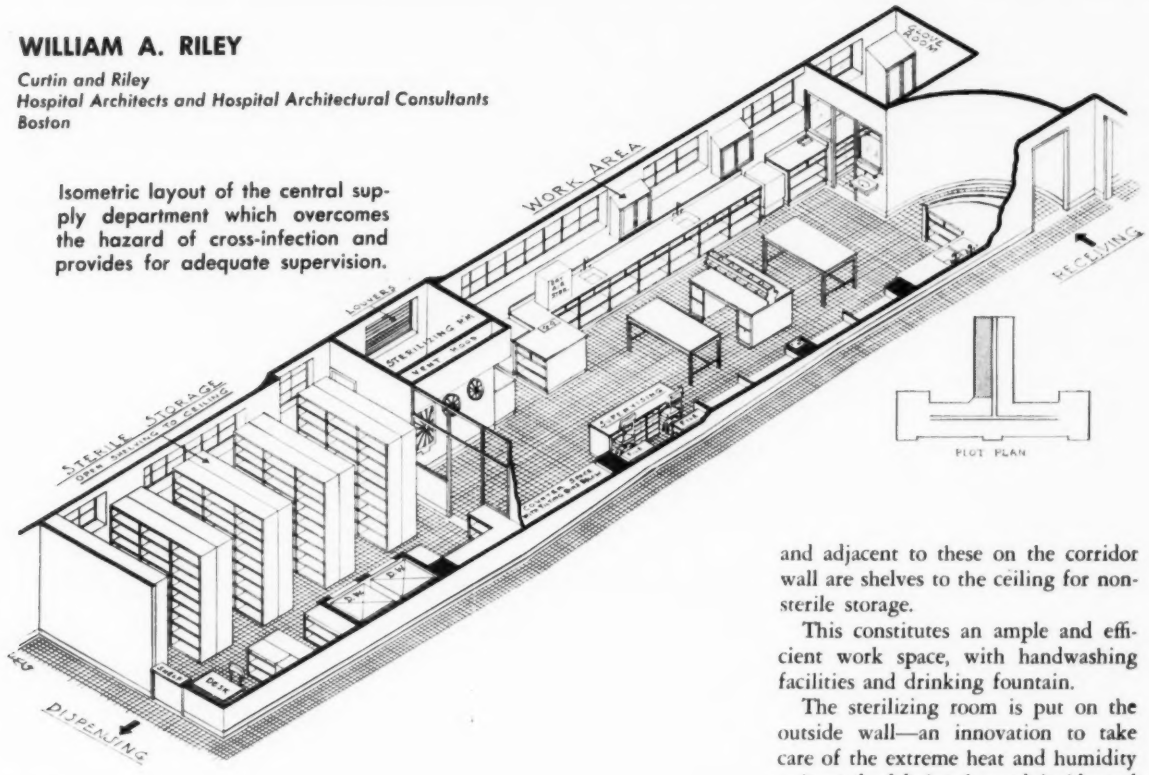
If we can get all this going, I think medical records in small hospitals will just automatically improve!

New Burbank Hospital Offers

Something New in Central Supply Layout

WILLIAM A. RILEY

Curtin and Riley
Hospital Architects and Hospital Architectural Consultants
Boston



Isometric layout of the central supply department which overcomes the hazard of cross-infection and provides for adequate supervision.

THE unit shown here will be incorporated in the new hospital building at Burbank Hospital, Fitchburg, Mass.

This layout is the result of many years of intensive study during actual construction of central supply departments, and is the last word in convenience and control.

A solution gained by trial and error methods is always superior to that resulting from even the most elaborate charting of hypothetical process flow, and represents a practical, down-to-earth basis of approach appreciated by the skilled technician actually using the facilities, and illustrates its advantages even to the casual layman observer.

The difficulty with a wide area department is the impossibility of arranging the process flow in such a manner as to preclude the danger of infection from cross traffic flow.

In brief, if nonsterile traffic crosses the path of sterile flow, infection is possible and very probable.

We have observed this error in many central supply layouts—even some of those most recently constructed.

The wide area plan is also difficult to fit into the modern hospital planning.

Process flow, to be more efficient and avoid cross infection, favors the in-at-one-end and out-the-other technic—fitting into modern hospital planning better with its longer, narrower axis arrangement. The difficulty encountered in this type of planning is that of obtaining satisfactory centralized supervision.

In the layout shown here we feel that this problem has been solved.

Nonsterile goods are received at one end of work area, where are located the deep sinks for cleansing, the enclosed glove cleaning area, the long counters with space for sinks, small sterilizers, hot plates, bottle washers, and so forth, with drawers and open shelving under, and wall storage cabinets above, ending with the stills on wall of sterilizing room. In the center of the work area are the worktables, and adjacent to these on the corridor wall are shelves to the ceiling for nonsterile storage.

This constitutes an ample and efficient work space, with handwashing facilities and drinking fountain.

The sterilizing room is put on the outside wall—an innovation to take care of the extreme heat and humidity—instead of being located inside and creating a difficult problem of ventilation, as is done in most instances, even in recent construction. A hood in front of the sterilizers removes still more excess steam and dampness.

All solutions are made outside the hospital.

The sterile storage area, with open shelving to ceiling and direct access to dumb-waiters to floors above, has a dispensing door through which pass the sterile storage trucks to an adjacent service elevator.

The centralized supervision is self-evident from the drawing. From the central supervising desk the whole work area and sterilizing area are under direct control, and glazed partitions give visual control of glove room and sterile storage area through to the dispensing door, augmented by buzzer and telephone intercommunication system.

The layout, which has direct dumb-waiter as well as service elevator connection to nursing units, operating, x-ray, and delivery departments above, serves about 400 beds.

The new admitting office at St. Francis Memorial Hospital, San Francisco. A machine for transmitting written messages to the laboratory as soon as the patient's history has been taken has speeded up the admitting procedure.

SPEED UP Admitting Procedures to BUILD UP good relations with patients and staff

GEORGE WILLIAM WOOD
Administrator, Antioch Community Hospital Association, Antioch, Calif.

THE majority of people who are hospitalized for the first time regard the admitting procedure as an unnecessary part of patient care. An inadequately staffed, imperfectly organized admitting office can aggravate the condition of emotionally unstable patients and color their attitude toward the hospital's service. A patient's only concern at the time of admission are the mysteries that lie ahead.

St. Francis Memorial Hospital became aware of an increased load of admissions in 1948. This trend developed as a result of new discoveries in the field of antibiotics and a rapidly increasing number of subscribers to group hospital insurance. Developments of this kind produce a reduction in patient stay, an increase in patient turnover, improved medical care, and a greater volume of work in all departments. St. Francis Hospital's admitting office was not prepared for this change. An inadequate staff of one person for each shift completed an average of 40 admission forms per day. These were prepared in longhand. Routine laboratory and x-ray examination requests were sent by messenger to the respective departments. The consequences of employing this type of operation became progressively worse as the volume of work in admitting patients increased. Late admissions meant an adjustment in physicians' preoperative orders and confusion and delay in the various ancillary services. Complaints from our guests were numerous.

In order to meet the greater volume of work in a given period of time we created a pattern of control in the admitting office which has proved to be extremely successful.

PRE-ADMISSION PROCEDURE

One of the most effective means of speeding up the entire admitting process was the development of an organized pre-admission procedure. The pre-admission letter and confidential questionnaire were created for cases for which the physician requests a reservation one or more weeks in advance of the admission date. These forms are mailed with a return envelope to the patient.

When a reservation is scheduled within several days of the admission date, the admitting nurse calls the patient by telephone and asks for the information that normally would be completed on a confidential questionnaire. A few physicians will not permit their patients to divulge confidential information except during the interview at the time of admission.

The only disadvantage of using a pre-admission letter and questionnaire is that misinterpretations and incomplete answers may result. Sometimes, of course, a patient will not even bother to return a questionnaire.

The advantages, however, are a considerable reduction of time in interviewing patients at the time of admission, elimination of a crowded admitting office with long waiting periods for ill persons, and better coordination between surgery and ancillary services.

Information on patients who have been admitted to our hospital in the

At the time this article was prepared, Mr. Wood was administrative resident at St. Francis Hospital.

past is obtained from the old record, but the patient must verify his address and the like.

It is estimated that at least 50 per cent of all patients admitted to St. Francis are interviewed by telephone or mail; the other 50 per cent consists mainly of patients who live in distant cities, maternity cases where the admittance date is uncertain, and emergencies.

BED ASSIGNMENT

Although many of the reservations are made prior to the admission date, the actual bed assignment is scheduled either the day before or the day a patient enters the hospital. The admitting nurse will endeavor to comply with special requests of patient or physician, *i.e.* one physician will prefer to have all his industrial cases in a particular ward and another will want all his fenestration cases in a particular section of the fourth floor, and patients' requests will depend on their ability to pay for private care.

Physicians are often unable to write out doctor's orders at the time their patients enter the hospital because of a heavy schedule at their office. Therefore, the admitting nurse is authorized to take doctor's orders by telephone. Subsequently, these orders must be signed by the physician.

ADMISSION INTERVIEW

All of the information on a completed pre-admission form is recorded on the admission form prior to a patient's entry. An admission form must be completed at the time of admission for those patients who have not been interviewed through the pre-admission procedure. St. Francis Hospital's admitting form comprises five sheets: an original for legal purposes, a copy of the original for the admitting office record, a discharge slip, an admission form for the patient's chart, and the reverse side of a ledger card. One one-time carbon separates the five forms, eliminating unnecessary typing.

Operating permits on surgical cases are signed and witnessed at the time of admission. If a critical emergency case is brought in for surgery, then the nearest relative or physician may sign the permit.

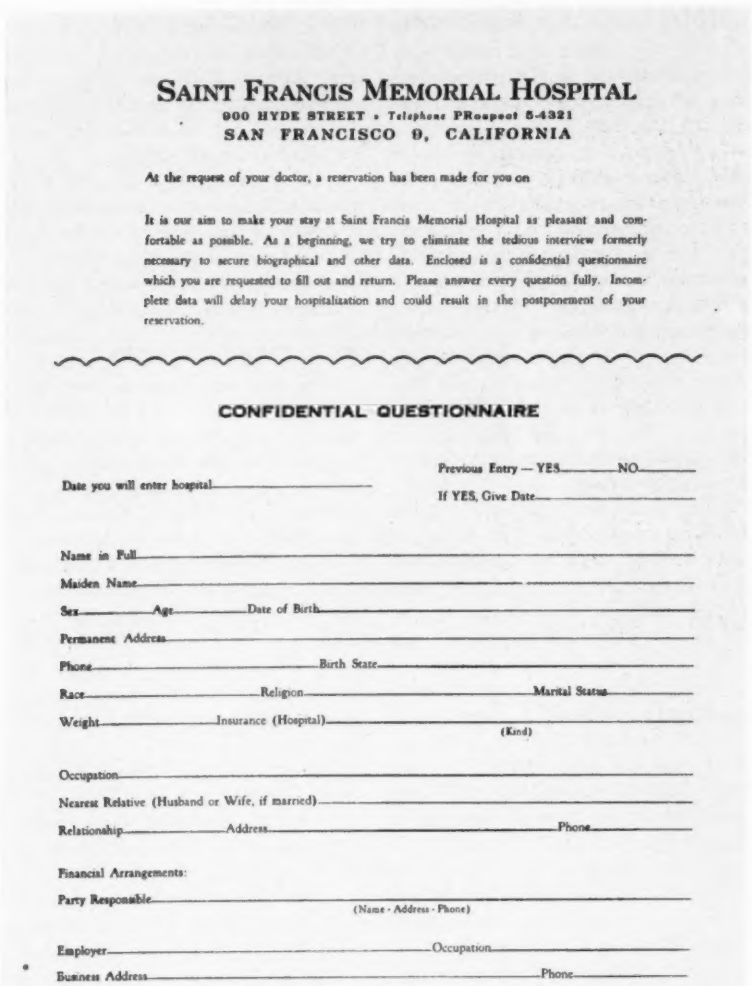
INTERCOMMUNICATION

One of the most useful improvements in the admitting office has been the installation of a patented written message system. The written message machine has been installed in the admitting office and laboratory. After the admitting nurse has completed an interview, the patient's name and data are recorded on the machine in the admitting office. This information is automatically transmitted to the laboratory machine. Because seven floors separate the laboratory and admitting office, the mechanical written message system has proved highly satisfactory. Prior to this arrangement information was carried by messenger, resulting in slower service and misplaced data.

In addition to the written message system an intercommunication system has been introduced that connects the admitting office with surgery, x-ray department, ambulance entrance, and laboratory. The admitting nurse may contact these departments by direct communication and eliminate an unnecessary amount of calls through the hospital PBX system.

A recently developed stencil system in the various nurses' stations provides an accurate means of recording the patient's name, room number, age and physician on all charges and forms that make up the patient's chart. The stencil originates in the admitting office. Prior to this innovation the stenciled information was recorded in longhand, resulting in errors of interpretation in the various departments, especially the record room.

Excellent service is the most important means of improving our public relations in the community. Modern hospitals should strive to improve their service beyond the goal of providing adequate patient care.



SAINT FRANCIS MEMORIAL HOSPITAL
900 HYDE STREET • Telephone PRospect 5-4321
SAN FRANCISCO 9, CALIFORNIA

As the request of your doctor, a reservation has been made for you on

It is our aim to make your stay at Saint Francis Memorial Hospital as pleasant and comfortable as possible. As a beginning, we try to eliminate the tedious interview formerly necessary to secure biographical and other data. Enclosed is a confidential questionnaire which you are requested to fill out and return. Please answer every question fully. Incomplete data will delay your hospitalization and could result in the postponement of your reservation.

CONFIDENTIAL QUESTIONNAIRE

Date you will enter hospital_____ Previous Entry — YES_____ NO_____
If YES, Give Date_____

Name in Full_____
Maiden Name_____
Sex_____ Age_____ Date of Birth_____
Permanent Address_____
Phone_____ Birth State_____
Race_____ Religion_____ Marital Status_____
Weight_____ Insurance (Hospital)_____ (Kind)

Occupation_____
Nearest Relative (Husband or Wife, if married)_____
Relationship_____ Address_____ Phone_____

Financial Arrangements:
Party Responsible_____ (Name - Address - Phone)

Employer_____ Occupation_____
Business Address_____ Phone_____

Samples of the pre-admission letter and confidential questionnaire sent to those patients whose physicians have requested advance reservations.

What Medicine Has Done to Nursing

Abandonment of routine bedside duties—under pressure of medical and economic necessity—is robbing the nurse of the time to "see and nurse the whole patient"

DOROTHY V. WHEELER, R.N.
Director, Nursing Service, Veterans Administration, Washington, D.C.

HOSPITAL administrators are painfully aware that the greatest cost of a hospital is salaries of personnel, and the greatest portion of salary cost is for professional and nonprofessional nursing personnel. When pressures to cut costs develop, the first place you look is, naturally, at the overwhelmingly large service called nursing service, which, like a bottomless pit, absorbs scores of people, demands additional equipment and supplies with which to work, sends costs skyrocketing, and continues to harass you with the never-ending plaint that "we haven't enough nurses!"

NURSING IS WHIPPING BOY

In less vexatious moments many administrators and chiefs of staff acknowledge that modern medical methods and programs place an ever-increasing burden on nursing. They understand that, regardless of the medical program, and purely from a mathematical standpoint, it takes at least 4.2 nurses to provide *one* nurse on *one* unit for *one* week. Yet it is not unique to have those same hospital administrators and medical directors use nursing service as the "whipping boy" when budget time rolls around or reduction in force appears imminent. This is not surprising because, inevitably, there sits nursing with the vast bulk of hospital personnel. In a hospital with a total personnel ceiling, let us say, of 800, nursing service may actually have 350 to 375 positions, and be asking for more!

I contend that nursing service, at a modest estimate, should probably have well over 60 per cent of all hospital personnel, rather than around 40 or 45 per cent which is currently considered generous, and in many cases does not exist. I base my contention on the fact that nursing service provides coverage of hospital units for *more than four times* the number of hours a week that most other types of hospital personnel do (dietary excepted—and even there nursing coverage is considerably greater). In addition, nursing service frequently assumes the rôle of admitting clerk, ward secretary, errand boy, telephone operator, elevator operator, housekeeper, and other odds and ends during large portions of those 128 hours a week that are in excess of the usual 40 hour work week.

Despite the fact that we must plan on nurse coverage on a unit for a 168 hour week rather than a 40 hour week, do we ever think of dividing the number of nurses by 4.2, or even by 3 or 2, when comparison of nursing pay roll with that of other departments is being made? Let us ignore for a moment the necessary supervisory, administrative, special unit, and head nurse groups, and assume that you have 125 staff nurses for general duty assignments on 25 ward units. At a cost of around $500,000 a year in salaries, five nurses per ward sounds like a lot—but is it? To have only *one* staff nurse on each of the 25 wards at all times would require 105 of the nurses with no consideration for sick leave, holidays or vacation time relief. The 20 nurses left are scarcely sufficient even to begin to fill the vacant spots on those wards, where more than one staff nurse is needed, and to provide relief for holidays, illness and vacations.

It is inconceivable that an experienced administrator would consider such nursing coverage adequate for safe patient care on any busy ward in any one of our hospitals. Yet, daily, we place nursing executives in our hospitals in a defensive position about personnel and add to their work load by requiring justification for retention of their limited staffs and to their worries through constant threat of the falling ax.

WHAT CAUSES THE INCREASE?

Why the vast increase in nursing service personnel? Why does an agency like the Veterans Administration, for example, have 14,000 nurses now, when in 1945 it got along with approximately 4000? While it is true that there has been an increase in numbers of Veterans Administration patients and Veterans Administration hospitals, those increases have certainly not been proportionate to the increase in nursing personnel. The fact is that we believe we need at least 20,000 nurses right now to staff our hospitals properly.

The answer in Veterans Administration hospitals, as in others, lies in the medical care methods, theories and programs which have been developed in the past decade or so. Of course, it is also due to the reduction to a 40 hour from a 48 hour week and to an eight-hour from a 10 or 12 hour day. Certainly these national, social and economic trends applying to all employed persons, including directors of nursing services and hospital administrators, *have* increased the need for personnel, but not to the extent that

Condensed from a paper presented at the Seventh Inter-Agency Institute for Federal Hospital Administration, Walter Reed Army Medical Center, Washington, D.C.

advances in medical care have done. Even with a 48 hour week it took three or more nurses to provide one nurse on one ward for one week, 24 hours a day.

Nursing critics say, "Yes, but look what modern medical science has done to reduce nursing activities!" Chemotherapy, they point out, has reduced pneumonia to a minor nursing care problem, where previously only intensive nursing care on an every-minute basis would save the patient. Early ambulation following surgery means that the patient is in the operating room, out and back home in a fraction of the old time, with detailed bedside nursing reduced to hours instead of days, postoperatively. Administrators compete to reduce hospital stay and are understandably proud of the high turnover of patient population in their hospitals.

What many of the critics fail to understand is that each time the length of hospitalization of a patient is shortened it adds to the nursing burden: another discharge procedure to go through, another bed unit to clean and prepare—and, inevitably and usually simultaneously, another admission, another preoperative preparation, and another new surgical patient with all the suctions, transfusions, chemotherapy regime, and the like to look after. Our hospitals used to have a graduated scale of surgical patients—preoperative, new postoperatives, several days postoperative, and convalescent, and there actually were moments when the nurses could breathe freely between cases. Intensive medical care and speed-up of discharge have produced a sustained, intensive nursing load which permits no letdown.

CHANGES IN TB NURSING

The tuberculosis hospital provides a good example of what has happened in nursing. In the "good old days" of bed-rest and diet, all was peace and quiet and even the staff took a rest from 1 to 3 p.m.! Walk through any of our modern tuberculosis hospitals today, and you find the counterpart of an active medical and surgical hospital, the only difference perhaps being that the gown-cap-and-mask technic creates an added, time-consuming element in all nursing procedures.

Medical care, and therefore nursing care, in tuberculosis has changed. The regime today is one of active rather than passive treatment. Courses of streptomycin, PAS and INH are given over specifically prescribed periods. The mixing, preparation, administration and recording of these medications are tremendously time-consuming, and it is not unusual, on a 40 bed ward,

Nursing technics have changed!

for as many as 30 patients to be under drug therapy at one time. This requires an increased number of laboratory procedures; in many instances the number of such procedures is triple what it was previously on the same ward. On whom does the burden of this program of therapy fall—who prepares the lab slips; makes trips to and from patients' rooms; prepares, administers and records the medications; prepares, cleans, and sterilizes the sets and needles?

In addition, patients under drug therapy require close observation and more bedside attention, since it is not unusual for these patients to suffer some disturbance in balance owing to action of streptomycin on the vestibular nerve. Tests must be done at stated intervals to determine the amount of hearing loss. More often than not a nurse is assigned the responsibility for this testing. Drug therapy also requires frequent routine specimen collection, and the problem of delayed meals arises constantly, with subsequent effects on ward nursing routines. Inevitably, nurses have the added burden of trips to and from the kitchen for late trays.

Similar illustrations could be drawn from almost any of the surgical or medical specialties—geriatrics, polio, cardiac, orthopedic surgery, and so on. In our hospitals generally, new mechanical devices, such as oxygen therapy equipment, iron lungs and rocking beds, pumps and all manner of intricate transfusion, infusion and suction apparatus, have necessitated that nurses today become not only skilled nurses, but also semitrained mechanics and electricians, since problems do not always arise conveniently during the week-day, daylight hours when the mechanics and electricians are on duty.

New drug therapy and intricate surgical and medical treatment plans demand that the nurse understand more completely than ever before the principles of pharmacology, medicine and surgery, or else the result of the medical care plan may be destroyed or never achieved, because the doctor cannot be on the ward every moment to follow through, and the responsibility falls on the nurse.

RESEARCH IS ESSENTIAL—BUT

Vital also to modern medicine is the opportunity for research and experimentation. No one quite replaces the nurse in some of the studies being conducted by our doctors, and, understandably, they want nurses to help with their projects. Understandably, also, the nurse wants to help and is professionally stimulated by participation in research. But she has only two hands and feet, can only be in one place at a time, and often her value in a research project is nil because she is harassed with the worries of a million undone tasks. So the doctors ask for a full-time nurse; they sell the idea to the chief of staff and the administrator, and a nurse is assigned to assist in the research project. If the nursing service director agrees to this with the understanding that another nurse will be needed for patient care on the ward from which the research nurse was lifted, somehow that understanding gets lost in the next personnel cutback shuffle, and the other nurses have more duties added to their schedules.

In addition to the demands on nursing service and the utilization of nursing personnel made by developments in medical care, we are concerned with how these changes affect the direct care of patients by nurses. For years—either willingly or grudgingly, graciously or ungraciously—nurses, hospital administrators, doctors and patients have accepted the fact that there must be a subsidiary group of nonprofessional personnel to assist nurses in the care of patients. As medical programs have changed and expanded, many technical and formerly medical procedures have been delegated to nurses. In turn, nurses have delegated to nonprofessional workers many procedures formerly considered wholly the responsibility of professional nurses. There is continuous and highly controversial discussion of *what* functions

belong to the nurse and what functions must, could or should be delegated to nurse's aides or other nonprofessional assistants. Myriad studies have been conducted, endless articles have been written, dozens of workshops, panel discussions, conferences and institutes have been and are being held on the subject, with no immediate, specific, satisfactory solution in sight.

All we know is that either by design or necessity the professional nurse seems daily to be having less contact with the patient. With this trend away from the bedside, we are, paradoxically, demanding through our new medical programs that the nurse be more aware than ever of all aspects of the patient's condition—mental, physical and emotional. The problem is that such awareness can be gained only by being with the patient in a nurse-patient contact of sufficient duration to allow time for authentic and accurate observation. In all good faith, we have tried to lighten the load for our nurses by training and assigning nonprofessional aides to make beds, give baths, do shampoos, take temperatures, feed, and perform dozens of other, less intricate personal care procedures. In so doing we have taken from the nurse the *natural* nurse-patient contacts which she previously used as an opportunity to get to know the patient and his worries, to observe his symptoms and reactions, and to do so without the patient's being aware of the fact that he was being skillfully observed.

LOSE OPPORTUNITY TO OBSERVE

It is true that almost anyone can learn to give a good bed bath. But can everyone learn to give a good bed bath as an incidental function while observing and recognizing the patient's physical and emotional condition and needs? Nurses have, since the beginning of modern nursing, used the routine daily care procedures as an introduction to their patients, an opportunity for unheralded and unrecognized health teaching, and a chance to win the confidence of patients and instill in them a confidence in the whole medical care and hospital program.

This fact was brought sharply home to me recently. In one hospital we were suggesting that the aides take the TPR's in order to relieve the nurses of that routine duty. (This was an old-fashioned hospital—nurses were still taking temperatures.) At the suggestion a great hue and cry arose from the head and staff nurse groups, who said that the TPR's were practically the only procedure left them which was of a type to permit unhurried observation and a bit of "getting acquainted" time with *every* patient *every* day. It might appear that that group of nurses has more insight into the basic problems arising from the changing concepts of nursing functions than do many of the rest of us.

Much is being made today of the revamping of the curriculum in medical schools, by including special courses and emphasizing throughout all courses the instruction of medical students in the art of bedside medicine, the return to the art of being general practitioners, the necessity of knowing, seeing and treating the person, not just the disease or the injury.

STRESS "WHOLE PATIENT"

For almost two decades nursing schools have been stressing the principle of seeing and nursing the whole patient and considering the individual, his mental, emotional, spiritual and social needs, as well as his illness. Yet, at the same time, changes in concepts of medical care, the need to reduce hospitalization costs through use of subsidiary personnel, increasing the nonbedside duties and responsibilities of professional nurses have tended to limit the nurse in her opportunities to get to know and minister to the patient as an individual. The theory unquestionably is good, but attempts to put it into practice are rapidly becoming a highly frustrating experience for the nurse.

Nurses are as proud of the new medical programs as are hospital administrators. Nor do we expect commendation for our part in the success of that program. Rather, we believe that doctor and administrator might reevaluate those programs in terms of what they mean when reduced to needs for nursing time. They must recognize that when the nursing service reiterates its plea for more nurses, it is in an effort to keep pace with what administrators and medical men are demanding in care of patients, and to provide total nursing care of the patients for whom we are responsible.

I am sure that nursing personnel could be reduced further, and fairly adequate custodial care of the ill could still be accomplished. However, it appears to us that the modern medical program would be intolerably hampered if nursing failed to keep pace, and will eventually lose its worth and meaning if the nurse is forced too far from direct bedside care.

Just as hospital planners, architects and builders have finally realized the need for medical and nursing consultation in hospital construction plans, it would appear that the time has come for medical men to take nursing and administration into their plans for developing the medical program, so that there may be a joint understanding of how far that program can go within the limitations imposed by the available supply of nursing service personnel. Before final decisions are made concerning the alteration, extension of medical care, and the introduction of new methods, it would seem that nursing service should be consulted and kept informed during the formulation phase of the anticipated program. This would facilitate planning in advance for nursing service coverage and needed reassignment of personnel and would assure more complete cooperation in the new program. At the same time, it would serve to alert administration and medicine to possible "road blocks" which may arise owing to insufficient or uninformed nursing personnel. Better to consider nursing needs prior to the inception of a new program than to have medical effort frustrated or wasted while nursing struggles to meet the new demands after final decisions have been made and the program has been started.

NURSE SHOULD BE CONSULTED

I do not wish to leave the impression that nursing service in any way expects to have an authoritative voice in determination of what medical care plan is to be followed. However, we have all seen medical programs fall short of success because more nursing time was required than could be made available. Preplanning by all groups concerned may frequently find a way to achieve the desired result; it is nursing's inclusion in the preplanning phase that we suggest, so that we may meet the nursing needs of changing medical programs, and still allow our nurses some time to get back to the bedside to meet the unchanging needs of the ill person. These can be met only by the professional nurse who is prepared to recognize and eager to meet them.

A group of high school helpers at Beth Israel Hospital receives instruction from nurse instructor.

The odds are 13 to 4 in favor of

High School Helpers in the Hospital

DANIEL S. SCHECHTER
Bloomfield, N. J.

IN AN attempt to cope with New York City's shortage of skilled hospital personnel, 150 specially trained high school girls now spend alternate two-week periods during their senior year as aides in 22 hospitals* throughout the metropolis. While gaining on-the-job experience in hospital work, each pair of girls fills a full-time position during the entire year.

These girls, all of whom have had a year of basic nursing at one of nine city high schools, have signified an interest in a hospital career. Some want to become registered nurses, others practical nurses, and still others laboratory workers, medical librarians or nutritionists. While they now are considered hospital personnel in that they receive their assignments from the directors of nurses, they are still, of course, under the jurisdiction of William Jansen, superintendent of schools, and of the cooperative education program of the board of education. If a girl drops out of school, she automatically resigns her job, which is viewed as part of the school course.

Duties most commonly performed by cooperative hospital aides include: bed baths, making beds with and without patients, feeding patients, giving soap suds enemas in a few hospitals, mouth washes, checking equipment, arranging flowers, preparing sets of linen, collecting sterile supplies, measuring female intake and output, and general nurse's aide duties. Assignments usually are in children's wards, women's wards, surgery, outpatient departments, and in the nursery.

Hospital administrators and nursing directors are, by and large, in favor of the program. However, some have expressed dissatisfaction, and the detailed comments "pro" and "con" are given hereafter. The majority look to today's high school students as a possible important source of future skilled personnel, and the experience of the entire cooperative education program so far seems to justify their optimism. While the program has been under way in commerce and industry since 1915, it only began in the hospitals in 1951. Of the first 114 hospital aides, graduating in June 1952 and January 1953, 23 are continuing professional training to become registered nurses; 16 are in training to become practical nurses, and 32 are continuing at their hospitals in other allied capacities, some until they can earn enough to pay tuition costs for nurse's training. Optimistic observers also find their hopes warranted by the fact that between 80 and 85 per cent of cooperative graduates throughout the entire program remain with their firms as full-time employes. This is an impressive record in view of the fact that there are some 3000 pupils in the program today.

Grace Brennan, the director of cooperative education, and her staff interview all applicants for hospital aide positions in an effort to find the right candidate for the right job. They are responsible, too, for the supervision of students who pass the screening test

*Beekman-Downtown Hospital, Beth Israel Hospital, Bronx Hospital, Brooklyn Hospital, Brooklyn Jewish Hospital, Jewish Memorial Hospital, Lebanon Hospital, Lenox Hill Hospital, Maimonides Hospital, Manhattan Eye and Ear Hospital, Mary Immaculate Hospital, Methodist Hospital, Montefiore Hospital, Mount Sinai Hospital, New York Hospital, Norwegian Hospital, Roosevelt Hospital, St. John's Episcopal Hospital, St. Luke's Hospital, St. Vincent's Hospital, University Hospital, and Wyckoff Heights Hospital.

and are placed. Each hospital, however, reserves the right finally to accept or reject prospective hospital aides, as it does all other staff members.

School officials are careful about the type of hospital selected for affiliation. For example, no youngsters are assigned to work with communicable cases. Also, an effort is made to keep them from acute situations which they might handle more calmly at 18 or 19 years of age, but which at 16 or 17 might terrify them.

Miss Brennan emphasizes that students working in hospitals are not assigned merely housekeeping responsibilities. She stresses also that nursing directors assign the girls according to their individual abilities, and that tasks given aides may vary from hospital to hospital. Although in other fields of the cooperative education program students working in pairs, first A then B, alternate a week in school with a week on the job, it was felt that since most patients remain in hospitals for about two weeks, the same period of work by aides might enable them to assist many patients through their entire stay.

PAID PREVAILING WAGES

Student aides are paid the prevailing wages of employes performing comparable tasks, and generally rank just below practical nurses. The policy of the board of education is to meet the wage law minimum of 75 cents per hour. The students work under the same conditions and receive the same benefits as other hospital personnel. They follow the regular schedule of the hospital (usually 40 to 44 hours per week), and they may be required to work on week ends, with equivalent time off during the week. However, because many of the girls have to travel considerable distances from their homes to the hospitals, they do not work late shifts. The board of education has ruled that cooperative students may not work after 8 p.m. or before 7 a.m. Their attendance and punctuality are recorded by the hospital for the school, and each girl is given a semi-annual rating for her job performance. The school system does what disciplining may be necessary in cases of tardiness, absence or broken rules; but these have not proved major problems.

The hospital aide program really had its inception at the Beth Israel Hospital, where during several summers after World War II high school seniors served as ward helpers or aides in an effort to stem the critical shortage of personnel. When six of these students returned to Wadleigh High School in the fall of 1950, their enthusiasm gave the chairman of the school's home economics department an idea. Together with Clare Casey, Beth Israel's director of nursing, she worked out a plan that won the approval first of Dr. Maxwell Frank, the hospital's director, and then of the board of education and the committee on the training and recruitment of hospital personnel of the Greater New York Hospital Association. This committee had begun studying the possibilities of hospital-school liaison in 1948.

About 450 students are participating in the academic and on-the-job phases of the hospital aide program. Pupils who may be enrolled in preparatory academic courses during their third or fifth term of high school may not begin actual hospital work until their senior year. By this time all of them have had a year's training in home nursing, nursery work, child care, nutrition or a combination of these fields. They take the regular academic subjects in addition to highly specialized courses in family relations, mother-infant care, diet therapy, nursery school work, child development, anatomy, physiology, biology, applied chemistry and so forth. The courses vary somewhat in the different schools.

The girls are trained in school by nurses who have entered the teaching profession and are employes of the city's education system. To ensure that the training is up to date and in accordance with the policy of the board of education, there is in each school a registered nurse who serves as a coordinator, under the cooperative education director, with the hospitals where her students are employed. From time to time she visits the institutions —but only after the cooperative education director has made an appointment—checking on whether the students have been trained properly to do a good job and whether they are being assigned opportunities for educational broadening as well as for service. While on active duty, the "co-ops" receive from a nurse supervisor an orientation to hospital life and continued instruction in nursing technics begun in the high schools.

How do administrators and nursing directors evaluate the hospital aide program? More positive than negative views were expressed.

Dissatisfaction was voiced by some hospital officials because:

1. Reteaching of students is necessary when they forget material covered in early home nursing courses. Also, there appears to be a lack of standardization in such courses.
2. Students show a need for Red Cross first-aid training.
3. The two-week school interruption in a student's hospital work necessitates much relearning upon her return. This is a disturbing factor to the charge nurse and the student.
4. Many students have not been sufficiently schooled in general hospital conduct and ethics.

THIRTEEN ADVANTAGES

The vast majority of the executives interviewed expressed wholehearted approval of the program because:

1. The high school students evidence keen interest in their work and ability to learn hospital routine.
2. They are unusually dependable as a group, perhaps because the program is part of school routine.
3. Because many students are interested in professional or practical nursing as a career, they may do better work than adult aides receiving the same assignment.
4. The students are in good health and receive high school examinations of their physical condition.
5. They are cheerful because they are in the field of their choice and enjoy the break in the school regimen.
6. Students have great sympathetic "understanding" of patients.
7. Because students have been taught simple technics by high school teachers, the length of the program of in-service education may be reduced.
8. Hospitals with professional schools may acquaint student aides with their programs and interest them in possible attendance.
9. The hospital aide program enables worthy students—potential hospital personnel—to continue their high school courses by giving them an opportunity to earn money.
10. The program relieves hospital nursing personnel of many nonnursing duties.
11. It reduces the frequent turnover of auxiliary workers.
12. Because student aides are assigned in groups, hospitals can anticipate better their personnel needs.
13. The program promotes good community relations for both the hospitals and the schools participating.

A 200 bed hospital shows how well

A Community Hospital Can Do Research

ALFRED E. MAFFLY
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SIR CHARLES HARRINGTON in his Shattuck lecture effectively analyzed the object of all research: "Research, pure or applied, is the acquistion of new knowledge and it is by its fruits, be they theoretical or practical, that any research effort will ultimately be judged."[1]

Research is an integral part of good medical care. Until recently the large university teaching hospital has held full sway in medical research owing to the mistaken belief that only large institutions were adequately equipped, in terms of personnel and clinical facilities, to make any major contribution. There is now, however, an increasing awareness on the part of the community hospital that research is an indisputable part of adequate community service.

POTENTIAL MEDICAL CENTER

Every community hospital should envision itself as a medical center serving the total medical needs of its sphere of influence. It becomes obvious that, to accomplish this, research must serve as a stimulus for growth. It is imperative that we consider research not as an auxiliary to patient care, but rather as a main pursuit in the care of the sick. More than 90 per cent of the prescriptions written by physicians today could not have been filled 15 years ago.[2] Although this revamping of our pharmacies has been, and will continue to be, to a large degree accomplished by extensive scientific research in the large medical schools, nevertheless in our community hospitals there are personnel and facilities waiting to be tapped.

Research can be classified as fundamental and developmental. It is recognized that fundamental scientific research is generally in the province of the large well equipped laboratory replete with technicians and specialists. Not so developmental research. Here the small hospital can take its rightful place. It can take the facts already uncovered in the first approach and make them useful from the practical point of view. Now, we are not dealing with guinea pigs but with patients—human beings. Guinea pigs are not ideal for research in human diseases. Guinea pigs don't have emotions like human beings and don't live under the tension that human beings do. Many new drugs which work effectively on research animals must therefore be tested also on human beings. The hospital can help provide such human beings and aid in research, whenever it can be done without damage to its patients. Here is where the community hospital can make its big contribution.

Research by its very nature is attractive to the community hospital staff. It sharpens its observations and stimulates careful thinking. For the individual who gives his time and effort to the research program it offers an opportunity for specialized service, personal satisfaction in contribution, and acceptance by his peers. The individual doctor and technician sees himself accomplishing something above the minimum requirements. Research conducted on the community hospital level by local citizens removes the aura of scientific mystery and makes the program a vital community project of real interest to the hospital staff, its families and friends.

MATERIAL IS AVAILABLE

A sound basic program of research can be initiated by most community hospitals. The medical records library is bulging with material for clinical study. Valuable data are accumulated in the medical records of the thousands of patients who go in and out of our community hospital doors each year. The medical records of our discharged patients have been allowed to stand on the shelves and accumulate dust instead of being used for clinical and therapeutic evaluation.[3] A comprehensive study of these records is costly only in time and effort and this is negated when one thinks of the opportunities for better patient care through this relatively simple medium of research. Then, too, use of autopsy figures offers a fertile field for evaluation of diagnostic procedures. These fields of community hospital research require no expensive laboratory facilities or technical personnel. With a well administered program of this nature the cooperation of the medical staff would be assured.

The community hospital is by no means excluded from specialized research programs financed by grants from research foundations and the Public Health Service. If the community is properly educated to the real need for the program, the necessary funds are forthcoming from many sources. Local physicians can be in-

[1]Harrington, Sir Charles: The Shattuck Lecture: The Rôle of the Basic Sciences in Medical Research, N.E.J. Med. **244:**777 (May 24) 1951.

[2]Wright, W. Alan: Accent on Research. J. Student A.M.A. **1:**37 (October) 1952.

[3]Hospital Care in the United States, New York, The Commonwealth Fund, 1938; Sloan, Raymond P.: This Hospital Business of Ours, New York, G. P. Putnam's Sons, 1952.

duced to donate fees they might receive from indigent cases on the wards. Local businesses and industries can be induced to participate in a research program when they are convinced they are furthering a demonstrated community need.

The chief aim of the research program started at Herrick Memorial Hospital in Berkeley, Calif., in July 1950 was to investigate the idea of using group approach to the problem of obesity. Herrick Hospital, a 200 bed private hospital, was chosen because of its interest in a wide range of community service programs and the particular interest and background of its medical department chief, internist and cardiologist, in overweight and the frequently related chronic illnesses. Funds for the project were made available through the bureau of chronic diseases in the California State Department of Public Health. The lively interest in problems of group activity among the staff of the state health department, the faculty of the University of California, and other local agencies provided an especially resourceful community in which to carry out this research.[4]

DEPARTMENT WAS CREATED

In order to conduct the study the hospital created a department of research directed by the chief of the department of medicine and administered by a public health administrator added to the staff of the hospital. Planning has been the responsibility of the professional public health administrator assigned to the project, the chief of the department of medicine, a clinical psychologist, and the 11 participating group leaders.

Obesity today is a prime public health problem as is evidenced by its relationship to chronic diseases. Insurance statistics and analyses of clinical records further testify to this fact. After preliminary investigation, it was determined that mere application of dietary therapeutic measures, in weight reduction, was not adequate.

The group approach to weight reduction was used at Herrick Hospital because earlier research of this type was found effective. Overweight people like to meet in a homogeneous group where the mental blocks are down, with a minimum of guidance from group leaders. Here, there is a kindred tie and the discussions can run the full gamut of personal problems and through skillful use of the resource leaders technological advice can be interwoven to the degree that it becomes personalized and meaningful in individual situations.

At the very beginning, and throughout the program, the press has cooperated in making the community aware of the problem and the group approach which Herrick Hospital is taking to solve it. Although some referrals were made by private physicians and clinics a large segment of the group was recruited through the interest stimulated by the press.

From the outset of the program the physical fitness and psychic attitudes of the participants were made of prime importance in order that workable homogeneous groups might be obtained. This was accomplished by complete physical examinations, including complete x-ray tests for lung pathology and cardiovascular findings. Interviews with nutritionists elicited information regarding food habits, patterns, attitudes and backgrounds. A battery of psychological tests was given, including the Minnesota multiphasic personality inventory. The cumulative effect of these tests served to eliminate the psychotic and intractable individuals from group participation in order that a workable group situation might be achieved.

The administration and medical staff have worked simultaneously to make the research program a symbol of healthy progress and achievement by the community. There are two noteworthy dangers to be avoided in a research program. First is converting the man truly interested in research into a business executive who is harried with problems and is unable to devote his full attention to the goal at hand. The second pitfall is that when the investigator is separated from his problems by too extensive a staff he loses much of the real worth of his training and experience.[5] The administration and medical staff have succeeded in utilizing the trained research workers available, and have permitted them freedom of time and effort to accomplish their ultimate goals.

The medical staff participating in the research program was stimulated further by an invitation from the U.S.P.H.S. to attend the 1952 Washington, D.C., conference on obesity.

Some 325 persons have actually participated in this educational program at Herrick to the end that the hospital itself has become a focal point in lives of the participants. In each of these persons one finds an actively participating public health educator who in the normal course of things talks over his group experiences among friends and associates. It is inevitable that the hospital's program of research per se is benefited, to say nothing of the benefits accruing to the persons receiving the needed information, some of whom, of course, are attracted to the program because of the therapeutic values to be gained.

The benefits accruing to the hospital in attracting outstanding leadership in diverse fields of endeavor are indicated by the persons interested in the research program from the standpoint of their professional status in the community.

PEOPLE WHO PARTICIPATED

Included in the part-time group leaders and participants are: (1) consultant, bureau of health education, California State Department of Public Health; (2) field work supervisor, School of Social Welfare, University of California; (3) nutritionist, San Francisco Public Schools; (4) professor, department of education, University of California; (5) director of health education, Long Beach City Health Department; (6) associate in social research, California Tuberculosis and Health Association.

It is obvious that participation by persons of this caliber contributes much toward making the program meaningful to the participants. A feeling of mutual respect was generated from the outset. For the recruited leadership the research program offered the opportunity of setting the group work program in action, and afforded the ability quantitatively to test the results which were forthcoming in terms of: degree of participation in groups; a chance to play a guiding rôle in a relatively new type of research, which as all statistics will testify is urgently needed by a large element of the population. The most rewarding feature from the point of view of the group leaders, however, was the satisfaction in the knowledge that they were working together with their fellow citizens on a program of

[4] A Study of Weight Reduction Using Group Methods (Report of Progress), Department of Research, Herrick Memorial Hospital, Berkeley, Calif., 1952.

[5] Starr, Isaac: On Stimulation of Research by Means of Grants—Its Promises and Its Dangers. Hosp. Management, 73:94 (September) 1952.

vital interest, and that the ultimate effect of the research program would be felt now, and not at some indeterminate future time when active participating interest had waned or ceased altogether.

The hospital for its part reaped incalculable benefits in terms of good will and community interest on a continuing basis. The participants began to think of the hospital as a resource freely available to them. It no longer seemed an impersonal institution designed to serve those who were acutely ill, but rather one that was interested in their day-to-day lives before illness became a reality.

Other departments of the hospital are testing the reliability of new drugs, in cooperation with the research being carried on by large pharmaceutical manufacturers; our psychiatric department is carrying on research with antabuse and the further use of curare. Our psychiatric staff also has been making a statistical survey of the psychiatric facilities in general hospitals in the U.S. and Canada, as a result of which it has already published several articles and is now publishing a book. The results of this survey have also been incorporated in an exhibit which has been presented at the conventions of the American Medical Association, American Hospital Association, and American Psychiatric Association.

THEY CAN WORK TOGETHER

The old outmoded idea that the public health department and the hospital are two separate and distinct entities which can never meet on a harmonious plane has been shattered by the Herrick research program on obesity. The fences have been broken down, and hospital and public health department alike have realized that each has much to offer within its own sphere to the other, and that, through teamwork, problems can be solved, and the community can reap the benefits in terms of better health.

In this project, the hospital furnished the technological equipment and skill and public health gave its trained personnel and knowledge of public health problems. Jealousy and rivalry were eliminated through a meeting on the common ground of mutual problem solving. Every community hospital and public health department could gain much through a realization of the benefits to be gained by pooling of resources and energies for the health needs of the community.

What Public Can Do About FEE SPLITTING

WHAT the public can do to help the medical profession curb surgeons and referring physicians who split fees was explained in an article entitled, "Patients for Sale," by Steven M. Spencer in the January 16 issue of the *Saturday Evening Post*. Mr. Spencer advised the patient or his relative to question each doctor about his fee and the method of payment.

"At the very moment when the medical profession has reached a shining pinnacle of scientific competence, having pushed back disease and disability on all sides and raised the average life expectancy of the people to a record high, it is under serious attack for the moral derelictions of some of its busiest members," Mr. Spencer said.

"The American College of Surgeons has been distressed by the number of reports and letters it receives from well qualified young men seeking a place to practice surgery and being told, in town after town, that there would be no business for them unless they conformed to the local custom of turning back 35 to 50 per cent to the referring doctors. . . .

"Whether fee splitting is a financial imposition on the patient or not, it is certainly, in many cases, a serious and dangerous physical one. For it often leads to unnecessary surgery, with the accompanying unnecessary risk, and to the family doctor's choice of a surgeon on the basis of the latter's commission arrangements rather than his competence.

"The removal of a healthy organ or piece of tissue is seldom perpetrated as a deliberate and intentional fraud upon the patient. The unnecessary operation usually comes about through the haste, pressure and professional covering up that so often characterize 'commercial surgery'. . . ."

What can the patient do about fee splitting? What steps can he take to protect himself against it? These questions were propounded by the nation's leading science writers at a press conference with the A. C. S. board of regents last October. Mr. Spencer quotes from the regents' reply, the full text of which follows:

1. Before he undergoes surgery, the patient or his responsible representative should talk to his own family doctor and to the recommended surgeon individually and separately and arrive at a financial understanding with each, the charges to be commensurate with the patient's ability to pay and with the service each doctor performs.

2. Except where he is attended by doctors practicing in a clinic group providing the necessary diagnostic and treatment facilities in one organization, by doctors who are partners in the same office or by doctors who are full-time employes of a hospital, the patient should expect to pay—in fact, insist on paying—each private practitioner by separate bill.

3. He should suspect fee splitting in any instance where the individual referring physician and the individual surgeon submit a joint or combined bill, for this is unethical according to the Principles of Medical Ethics of the American Medical Association as interpreted by the Judicial Council.

4. Above all, the patient should recognize that the services of the honest, conscientious general practitioner in making a correct diagnosis and in placing him in the hands of a good surgeon may be as valuable to him as the surgery itself and should be rewarded accordingly.

5. The key to public education against fee splitting is intelligent questioning of each doctor about his fee and how it can be paid, for fee splitting depends on the ignorance of the patient that a deal has been made between the referring physician and the surgeon. As a matter of self-protection, the patient should know who gets how much and for what.

PUBLIC WILL BE REASSURED

Spencer's article was accompanied by a statement from Dr. Paul R. Hawley, A.C.S. director, who said, "The careful reader of the *Saturday Evening Post* will not reach the conclusion that the majority of doctors are scoundrels, or that the medical profession has forfeited its right to the confidence of the public. On the contrary, he will be reassured by the knowledge that medical men of ability and integrity are earnestly striving to eradicate those evils which are not only harmful to patients but also bring great discredit upon a noble profession."

About People

Administrators


Franklin D. Carr

Franklin D. Carr, who has been administrator of Waukesha Memorial Hospital, Waukesha, Wis., since 1948, has been appointed administrator of Detroit Memorial Hospital, Detroit, effective March 1. Prior to accepting the administratorship at Waukesha, Mr. Carr had served as administrator of Door County Memorial Hospital, Sturgeon Bay, Wis. A former president of the Wisconsin Hospital Association, Mr. Carr is currently chairman of the A.H.A.'s committee on purchasing, simplification and standardization.


Robert M. Jones

Robert M. Jones is the new administrator of Waukesha Memorial Hospital, succeeding Mr. Carr. For the last two years, Mr. Jones has been assistant administrator of Columbia Hospital, Milwaukee, where he served his administrative residency following completion of his academic work at Columbia University in 1949 for a master's degree in hospital administration.

Jack H. Whittington has been named administrator of Brewster Hospital, Jacksonville, Fla. Formerly, Mr. Whittington was personnel administrator of Stamford Hospital, Stamford, Conn., and had held a similar position at Norwalk Hospital, Norwalk, Conn. A member of the New England Hospital Assembly, Mr. Whittington has also been a member of its traveling institute faculty. In addition, he holds a membership in the Connecticut State Hospital Association and has served on its personnel committee.

Hugh Spall, assistant administrator of Montana Deaconess Hospital, Great Falls, Mont., for the last five years, has resigned to go into business for himself, and **G. W. Ashley** has been named his successor. Mr. Ashley is the former administrator of Toole County Memorial Hospital, Shelby, Mont.


Warren G. Rainier

Warren G. Rainier has been named director of Mountainside Hospital, Montclair, N.J. Mr. Rainier went to Mountainside in 1948 as assistant director and became associate director in 1951. His master's degree in hospital administration was received from Columbia University. He is a past president of the Assistant Hospital Administrators Society of New Jersey and is a member of the American College of Hospital Administrators, the New Jersey Hospital Association, and the A.H.A. **Edith W. Johnson,** director of public relations, has been appointed assistant director.

Nellie G. Brown, superintendent of Ball Memorial Hospital, Muncie, Ind., for 20 years before her retirement several years ago, has been named administrator emeritus by the hospital's board of directors.


Reuben H. Denning

Reuben H. Denning has been appointed assistant manager of the V.A. Domiciliary, Camp White, Ore. Previously, he was personnel officer of the V.A. Hospital at American Lake, Wash. Mr. Denning received his master's degree in hospital administration from Northwestern University and was the 1953 recipient of the Mary McGaw Award. He also holds a degree from the Harvard Graduate School of Business.


Harold C. Mickey

Harold Chandler Mickey has been named administrator of Rochester Methodist Hospital, Rochester, Minn. Since 1949 Mr. Mickey has been with a firm of hospital consultants and also has served as lecturer in the school of public health of the University of Minnesota, where he conducted a course in hospital administration. He is a member of the American College of Hospital Administrators and the American Public Health Association, as well as the Minnesota Hospital Association and the A.H.A.


William J. Woodin

William Jackson Woodin has been appointed assistant general manager in charge of personnel administration at Memorial Center for Cancer and Allied Diseases, New York City. Mr. Woodin's previous positions have been in the fields of personnel and operations management in private industry.

Mary Stone Conklin has retired as administrator of Hackensack Hospital, Hackensack, N.J., and **Martin S. Ulan,** assistant administrator since 1950, has been named her successor. Mr. Ulan was chairman of the department of pharmacology at Rutgers University before he was appointed assistant administrator of the hospital. He holds a bachelor's degree in pharmacy and a master's in biology from the Philadelphia College of Pharmacy and Science, and is a fellow of the American Association for the Advancement of Science and the American College of Apothecaries.


Warren R. Von Ehren

Warren R. Von Ehren is the new administrator of Bellin Memorial Hospital, Green Bay, Wis. The former administrative assistant of the A.M.A.'s Council on Medical Education and Hospitals succeeds **Alida M. Jacobson, R.N.,** who is retiring after 20 years of service to the hospital. Prior to joining the A.M.A. staff two and a half years ago, Mr. Von Ehren was assistant superintendent of Bronson Methodist Hospital, Kalamazoo, Mich. He is a graduate of the program in hospital administration of Northwestern University and is a nominee

(*Continued on Page* 200)

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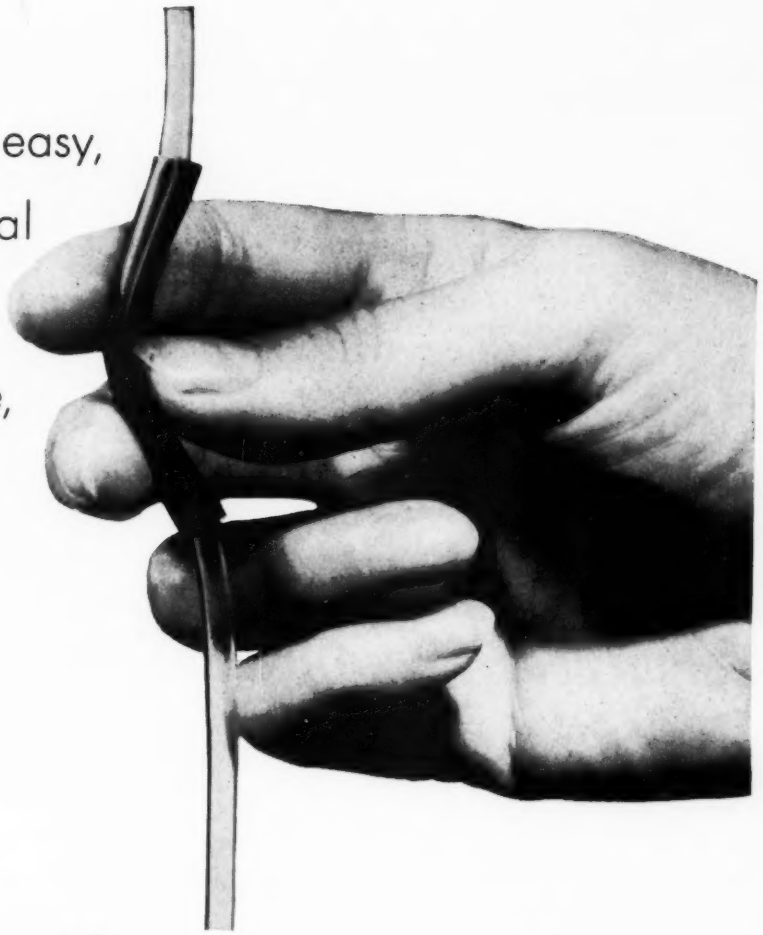
so practical
it's hard to
believe,



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Volunteers Make a Good Hospital

THOMAS EARLE DWYER
Veterans Administration Center, Dayton, Ohio

THE Voluntary Services plan of the Veterans Administration (VAVS), designed to provide supplemental assistance to the professional staff in care and treatment of hospitalized veterans, now is in its seventh year of operation and has proved of such merit that it has intrigued the interest of management in many voluntary hospitals, some of which are adapting the plan to their own requirements for expansion of service in the face of critical personnel shortages.

Established on the national level in 1946 with but six organizations represented on its national advisory committee, VAVS has expanded to include more than 40 organizations, each of which, to warrant such representation, must have sufficient units to be capable of operating in at least 50 per cent of the V.A. facilities.

The kind of service a hospital wants must be intelligently directed, efficient, enthusiastic and dependable, so that it will be good for patients and helpful to the professional staff. Such service depends upon real effort and planning within the hospital and also requires an untold amount of behind-the-scenes planning and hard work on the part of the organizations from which volunteer workers come.

Under the VAVS plan, the hospital looks to these organizations to take responsibility for recruitment and for initial selection of volunteer workers, as well as for their preservice training. It also looks to them to withdraw from the hospital those volunteers who prove unsuited to the work. It counts on the organizations to keep volunteers coming, and, more than that, to keep them coming with enthusiasm and spirit. It looks to them for many other things as well, but these are the most important of the responsibilities the volunteer organization assumes.

Once it has recruited people, the organization must determine which of them are suited in skill and temperament to work in the hospital. While tests to determine aptitude and stability have been experimented with, in the final analysis the organization usually must depend upon sensitive, well informed interviewers to screen those who offer their services.

The paramount quality in volunteers which interviewers should seek during the screening process is that of *spirit*—of eagerness to serve. In his book "The Art of Board Membership" (New York: Association Press, 1950), Roy Sorenson stresses the indispensability of this quality in any group that serves without compensation of salary when he says: "And now abideth businesslike methods, social processes, spirit, these three: but the greatest of these is spirit." Certainly, morale and spirit form the very core of the VAVS plan; hence it behooves those who screen volunteers for hospital service diligently to determine the degree to which each is infused with the spirit of her mission

Perhaps the subtlest of all jobs that the voluntary organizations have is that of *keeping* volunteers so enthused. Inasmuch as spirit and morale cannot be legislated or ordered by an executive, they must result from a positive attitude reflected throughout the organization. From time to time volunteers have gripes that immediate supervisors must answer. Whether justified or not, such gripes must be met understandingly to enable volunteers to continue with their work with renewed belief in what they are doing.

To enlist the services of volunteers, participating organizations of the

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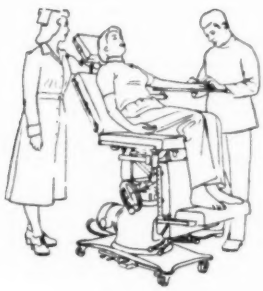

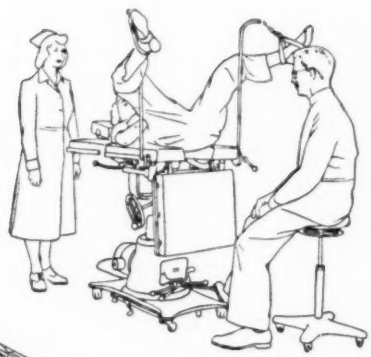

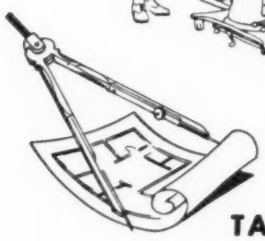

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Ask your Ritter dealer for a demonstration of the new Ritter Medium Surgery Table, or write for information to Ritter Company, Inc., Ritter Park, Rochester 3, New York.

Ritter

TAKE ADVANTAGE OF THE RITTER PLANNING SERVICE

One of the heaviest burdens of the nursing staff is "paper work." Here, a volunteer alleviates some of the burden by doing secretarial work.

VAVS annually conduct campaigns, usually during autumn months since experience has proved that there are normally fewer demands on the time of prospective workers at that season. Some organizations, such as the veterans' auxiliaries, draw their volunteers primarily from their own membership. Others may find it necessary to go into the community to recruit. Both types of organization must face the fact that, in most places, it is not easy to find people to do the jobs in hospitals. Because many new health agencies constantly are springing up and soliciting volunteer workers, the supply of interested people is reduced. Successful recruitment, therefore, now requires honest effort and considered planning. Window displays, newspapers, radio and television can be employed to get the word around, or speakers can be provided for clubs and civic groups to carry the story directly to their membership.

It is extremely important that those responsible for recruitment of voluntary workers for hospital service thoroughly understand the hospital story and are qualified to meet any arguments or questions on the part of those they approach. People want to know what sort of jobs have to be done by volunteers and must both be convinced of the need and assured that what they do will make a direct and significant contribution to the patient. Some are beset by fears, particularly where service is to be rendered tuberculous or mental patients, hence those responsible for recruitment must have available to them all pertinent information the hospital staff can provide.

Following recruitment, orientation and indoctrination classes of two-day duration are conducted by officials of the VAVS. Selectees chosen for integration into specific services, *i.e.* patient care, library service, occupational therapy, and recreation, are trained further prior to assignment. Those who are to serve as nurse's aides must qualify for such service by satisfactorily completing the standard Red Cross course for volunteer nurse's aides. Those who are to assist in occupational therapy receive a six weeks' course of training upon completion of which each receives a certificate as an occupational therapy aide.

To provide protective coverage and to qualify voluntary workers to receive periodic x-ray and other clinical check-ups, as well as to entitle them to meals should circumstances require them, all are processed by the Special Services Division of the V.A. and given the status of "Workers Without Compensation" (WOC).

Voluntary workers can assist the professional staff in many ways. They serve with the nursing service as supplementary ward and personal service workers or as nurse's aides; as library assistants; in central service; as motion picture projectionists (16 mm.); on the wards; as assistants in the dental clinic; in occupational therapy; physical therapy; social service; registrar and contact offices; blind rehabilitation; recreation, and in the domiciliary section, to mention but a few of the many hospital divisions which find their assistance invaluable.

WARD AND PERSONAL SERVICE

The duties performed by volunteers assigned to assist the nursing service as supplementary ward and personal service workers include:

Answering patient's call signal to ascertain needs.

Caring for flowers and fruits.

Directing or escorting patients as necessary.

Serving as hostesses when visitors need directing or reassurance.

Carrying food trays. Feeding selected patients as directed.

Delivering mail to patient's bedside.

Filling water pitchers and glasses.

Helping to rearrange and keep neat patient's bedside table.

Putting away supplies, caring for linen closet, helping with inventories.

Reading and writing patient's mail.

Shopping service; mailing service; miscellaneous errand service.

Telephone service for nonambulant patients.

Assisting in decoration of wards and other facilities for special occasions.

VOLUNTEER NURSE'S AIDES

Among duties of volunteer nurse's aides are those of:

Getting patient up in chair when directed.

Assisting nurse with admission and discharge of patients.

Cleaning dressing trays; cleaning and mending rubber gloves; cleaning and sterilizing enamelware.

Filling and applying prescribed ice bags and collars or hot water bottles.

Preparing patients for meals; feeding helpless patients; serving liquids and between-meal nourishment.

(*Continued on Page 96*)

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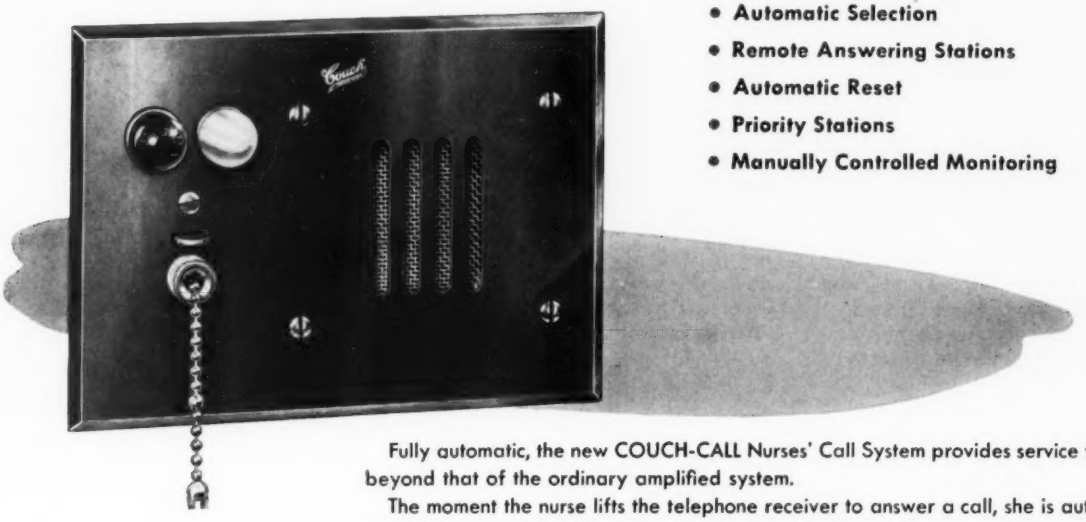

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Taking temperatures, pulse and respiration of other than seriously or critically ill patients.

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Giving baths—bed, tub or shower—including care of mouth, nails and hair.

Giving and removing bedpan.

Giving evening care.

Assisting in cleaning special equipment, such as oxygen apparatus or Wangensteen suction apparatus.

Assisting nurse with dressings.

Assisting with preoperative and postoperative care of patients.

Staying with patients who are receiving subcutaneous or intravenous injections.

Weighing patients.

Assisting patients with simple therapeutic exercises, as directed.

In addition to providing invaluable assistance to the nursing staff, VAVS workers contribute tremendously to the operations of other hospital services. In short, these VAVS workers make themselves generally useful anywhere and everywhere possible in performance of supplementary tasks which otherwise would burden and impede the work of the professional staff which directs their efforts.

Bert C. Moore, manager of the Dayton V.A. Center, stresses the value of one specific function, *i.e.* fire guard, for which the voluntary worker is peculiarly fitted. Obviously it is out of the question to assign a hospital employe to the bedside of each smoker during the smoking period. The voluntary worker fits ideally into the need. She is far more suitable than a staff employe could be for the simple reason that embarrassment engendered by being under "official" scrutiny of an employe might detract seriously from the patient's full enjoyment of his smoke. The presence of a volunteer worker enhances the pleasure and enjoyment of the patient, adding the touch of sociability to the period as the two converse while she remains alert to see that no harm results should he doze or drop his cigaret. Her conversation tends to keep the patient alert, also, and so greatly reduces possibility of his setting the bed afire.

Of extreme importance where volunteers thus serve as "fire guards" is the fact that during informal conversation with a patient while he is in a state of complete relaxation, much information may be divulged by him concerning symptoms or other facts pertaining to his illness which *should* be known to the professional staff but which he may be reluctant to mention to nurse or doctor. Such facts, once brought to light, may help tremendously with diagnosis and treatment.

Because the VAVS is a section of the Special Services Division of the Veterans Administration, in each V.A. hospital or center an official of that division serves as director of local volunteer activities. His major responsibility is to coordinate resources of participating organizations to meet the needs of the hospital services that utilize these contributions. Needs, in terms of personal service, materials, and so on, are predetermined from recommendations of heads of the utilizing services screened by Special Services. Regular meetings of the local VAVS advisory committee are held monthly, and before each member is placed agenda outlining needs during the ensuing month. Thereafter, agreement is reached as to the number of volunteers or the items of material each organization will provide. Personal service normally is apportioned upon a one-day-per-week-per-worker basis. This procedure assures smooth and continuous operation of the program.

To encourage volunteer workers to further the objective of the VAVS, periodic joint meetings of V.A. and VAVS representatives are held to discuss mutual problems, to iron out any difficulties which may arise, to clarify requirements of the program and to consider suggestions directed at closer collaboration and improvement of service to patients.

The V.A. Special Services Division annually features a Volunteer Recognition Service, a major ceremonial feature of which is the presentation by the hospital or center manager of appropriate certificates based upon the number of hours of work each volunteer has donated to the service. These attractive certificates denote accrued hours so contributed in denominations of 100, 300, 500, 1000, and so on.

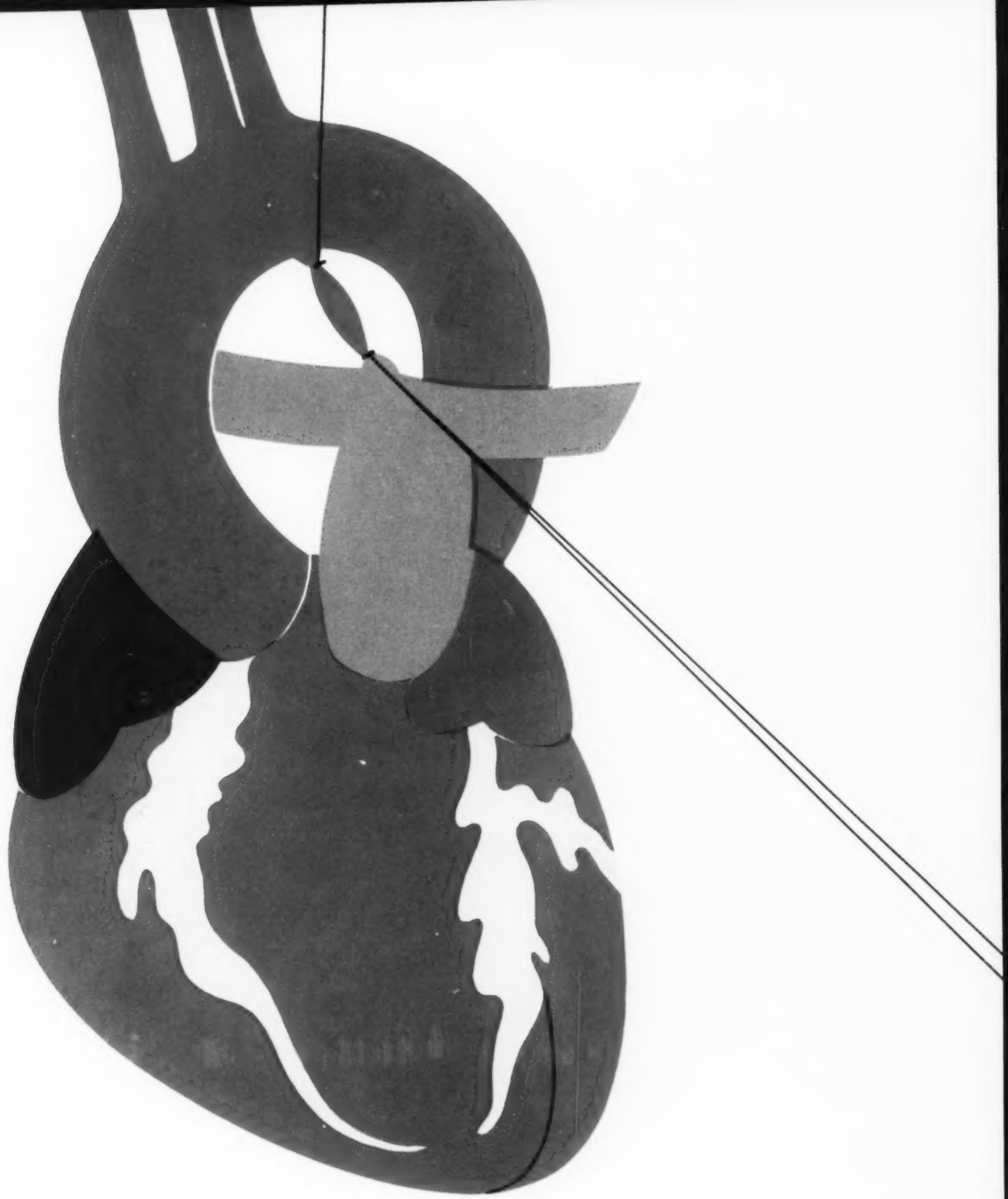
Often the service voluntarily contributed by workers of the VAVS literally becomes the "yardstick" used by veterans to measure the stature of the hospital itself. However fine may be the surgical, medical, nursing and other basic professional offerings of any V.A. hospital, the fact remains that its reputation among veterans depends chiefly upon the abundance of its offering of the "little extras" which a busy staff never could find time to provide but which voluntary workers of the VAVS *do* provide to relieve the irksomeness of hospitalization.

Personal experience gained from hospitalization in seven V.A. hospitals and four V.A. centers in various parts of the nation has convinced me of the truth of the frequently expressed opinion of veterans that "the best V.A. hospitals are situated in localities where people are kindliest." The word quickly gets around that it is a "good" hospital and this, in turn, strengthens faith in the proficiency of its professional staff. Such hospitals rarely have vacant beds.

An excellent example of the workability, effectiveness of, and benefits to be derived from the VAVS plan exists at the Dayton (Ohio) V.A. Center where service requirements of three hospitals—GM&S, geriatric and TB, with a total patient capacity at present of 989—plus a domiciliary section currently caring for more than 2000 disabled veterans have subjected the VAVS to a severe and exhaustive test.

Here, the VAVS advisory committee at present is composed of representatives of 31 service, welfare and charity organizations which provide more than 300 voluntary workers upon regular schedule and more than 1000 others to assist with special events. Indicative of the success attained by the VAVS plan at this V.A. center is the fact that during the last year voluntary workers contributed more than 65,000 hours of personal service. In addition, VAVS contributions in the form of materials, such as window draperies, objects of art, radio receivers, television sets, recreational equipment, furniture, and so forth, have done much to make hospitalization far more tolerable, satisfactory and efficient from the point of view of the patient.

Here most emphatically is demonstrated the truth of the adage: "Service finds its own reward." For volunteer workers of the VAVS not only are tremendously benefiting others by their contribution but are finding in hospital service a means of expression for one of the deepest and richest instincts of people—the *desire to help.*



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Chest X-Ray Programs Are Becoming Routine

DAVID GOODMAN
Milwaukee

IT IS doubtful that more than 100 hospitals in the United States in the year 1947 were routinely making x-ray examinations of the chests of all patients admitted. In that year, through the joint effort of the National Tuberculosis Association, the American Hospital Association, and the U.S. Public Health Service, a program was launched designed to promote this technic as a measure for screening out cases of chest disease.

Today, according to the latest count reported in an official directory dated June 1953, a total of 1898 of the 6192 hospitals reporting said they were providing routine chest x-rays for patients on admission. Perhaps this is an optimistic figure. It is generally conceded that to be effective and meaningful a program should cover at least 60 per cent of all admissions, and it is quite likely that many of those hospitals reporting actually do not screen that proportion of their patients.

However, the fact that great progress has been made is obvious; also obvious is the fact that the merit of the program is becoming recognized by an increasingly larger number of hospitals.

Most important is the growing realization among hospital superintendents and radiologists alike that the routine x-ray examination of chests is not just another chore to be laid upon an already burdened staff, but is a vital part of the screening procedure and an essential measure for the self-protection of the staff.

To be sure, a hospital can be operated without such a program, but the question that hovers over the head of every administrator is—how well? In a study undertaken at a major university hospital recently, a noted radiologist found that, on the average, the staff made one gross error per day in diagnosis, which could have been avoided had a routine chest film been taken.

At another hospital, a surgeon who had at first been opposed to the program became its most enthusiastic supporter. After it was instituted, one of his patients, scheduled for a serious operation, was found to be a major anesthetic risk, thanks to a routine film which revealed active tuberculosis previously unknown to the doctor or patient.

In August 1952, the Wisconsin Anti-Tuberculosis Association published the results of a survey of hospitals in the state. Of the 110 general hospitals reporting, 22 were engaged in a satisfactory program of routine chest x-ray tests, and 13 more were planning to do so. These 22 reported finding (among 10,000 admissions per month) about 100 cases of tuberculosis and 900 indications of other diseases —each month!

Translate this in terms of 18,237,118 hospital admissions in all U. S. registered hospitals (for the year 1951) and we can see the tremendous potential this program has in the detection and treatment of disease, even if radio-

Left: The x-ray technician at St. Luke's Hospital, Milwaukee, hands patient her admission papers after x-ray test has been completed. Right: Photo-roentgen installation at the Driscoll Foundation, Children's Hospital, Corpus Christi, Tex.

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ROUTINE CHEST X-RAYS IN HOSPITALS FIND

Sources for the figures shown here are as follows: "4"—from A.H.A. newsletter for September 1952; "6"—from "Routine Admission Chest X-Rays in Wisconsin," by John P. Hein, consultant for the Wisconsin Anti-Tuberculosis Association; also on figures from Deaconess Hospital, Milwaukee; "20"—median figure taken from original literature issued jointly by the A.H.A., N.T.A., and the U.S. Public Health Service.

graphic screening is limited to adults and teen-age youth.

According to the Wisconsin survey: "Neither equipment problems nor the availability of adequate radiological services present insurmountable obstacles to admission x-ray programs, even for the small hospital with fewer than 50 beds. Estimates of actual costs of the program vary rather widely among the 22 hospitals reporting. Charges vary, too, but the hospitals generally seem content to realize in fees from the patient the actual cost per admission film. Some hospitals deduct such charges from later diagnostic films suggested by the smaller x-ray.

"Although the study yielded no suggestion that hospitals doing admission x-rays have encountered serious difficulties in their fees for the service, there can be no doubt that wider acceptance of an admission film as an item covered by hospitalization insurance plans would stimulate the program in Wisconsin."

In addition to the three societies mentioned, four other key organizations in and associated with the medical field have given their public endorsement of the program—the American Medical Association, the American College of Radiology, the American College of Chest Physicians, and the American Nurses' Association. In a statement appearing in the June 1952 issue of *Diseases of the Chest*, the A.C.R. and A.C.C.P. go a step further than they did in the original 1947 program launched in cooperation with N.T.A., A.H.A. and U.S.P.H.S. Here they urge that:

"Each physician should be encouraged to have a chest x-ray made on all of his patients; that every patient admitted to a hospital, private or public, should have a routine chest x-ray, and that the follow-up for all suspected lesions seen in chest x-ray surveys should be organized very carefully to assure that the patient comes under medical supervision."

The principal obstacle to the more rapid acceptance of the routine x-ray program has been, strangely enough, not the cost, but the uncertainty as to the cost. Not enough publicity has been given to already published studies, which have fixed the expected costs within certain definite limits—limits which should not provide any great problem in enlisting public acceptance.

The classic economic analysis of routine chest x-ray was presented in summary form by Russell H. Morgan, M.D., of Baltimore in the September 1951 issue of *American Review of Tuberculosis*, with the conclusion that "from an economical standpoint, mass chest surveys are feasible in small hospitals" (100 beds).

He takes the case of a 100 bed hospital with 2000 or more admissions per year: "In such a hospital, an economical arrangement can be achieved usually by placing a photofluorographic hood and cut-film camera within a room of the department of radiology. The capital equipment, in a department of radiology today, costs approximately $7500. The regular case-load in a hospital of this size approaches 16 patients per day.

"Since the photofluorographic portion of this load constitutes one-third of the total, one-third of the cost of capital equipment (or $2500) should be amortized against the routine chest procedures. To perform the photofluorographic examinations, a hood and cut-film camera will be needed. If all the equipment is amortized on a 10 year basis and 2000 examinations are done each year, the total equipment costs would be about 25 cents per film. The costs of service, film and developing chemicals, and personnel will approach $100, $140 and $700 respectively."

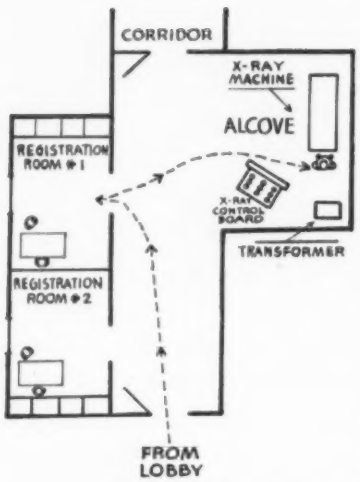
The over-all annual budget for a 100 bed hospital performing routine chest examinations, according to Dr. Morgan's figures, would total $1990. If 2000 examinations are performed in this yearly period, the cost per examination would be less than $1, or only 50 per cent greater than that encountered in large general hospitals. The experience in the large general hospital, where he found the cost to be nearly 70 cents, was based on the assumption of 15,000 examinations per year; the hiring of an x-ray technician and clerk-typist, and the nominal rental of 500 square feet of extra floor space at $1500.

Dr. Morgan found a charge of $1.50 per film to be both reasonable and necessary in small hospitals, in cases where neither public nor hospital funds are available to furnish a mass photofluorographic installation, where the radiologist himself provides the equipment.

He describes as "erroneous" the belief that these procedures become inefficient and costly when patients numbering fewer than 50 to 100 are examined each day.

What of the radiologist's compensation? Here Dr. Morgan states flatly that "it seems unreasonable that a physician who makes his living from radiological methods should forego revenue from so time-consuming a procedure (reading the routine chest films). These charges, which usually approximate 50 cents per film, bring the total cost of the photofluorographic examination in a small hospital to approximately $1.50."

It is interesting to note how closely Dr. Morgan's figures tally with those



From the *Crusader*, February 1953

Left: Layout for the routine chest x-ray unit at Sacred Heart Hospital, Eau Claire, Wis. Right: Dr. Russell H. Morgan's summary of costs of TB programs.

THESE ARE THE COSTS

Technical Costs	Large Hospital (approximately 15,000 admissions per year)	Small Hospital (approximately 2,000 admissions per year)
* Amortization of capital equipment on hand		$ 200
** Amortization of capital P.F. equipment	$1,200	200
Service charges	750	100
Photofluorographic supplies	1,200	140
Personnel	5,100	700
Rental of floor space	1,200	200
Utilities and extras	300	50
	$10,200	$1,590
Approximate cost per X-ray exclusive of interpretations	1.70	1.60

* Amortization of X-ray equipment already in operation in the hospital
** Purchase and operation of X-ray equipment solely for this program

as reported by Russell H. Morgan, M.D.
Johns Hopkins Hospital

issued by the Rev. A. H. Schmeuszer, superintendent of Deaconess Hospital, Milwaukee, whose six-year experience with routine chest x-rays has made this hospital the subject of numerous studies and frequent citation: At Deaconess (7200 admissions, 150 beds) a cut-film camera is used in conjunction with a tube and generator, which do double duty in regular radiographic work. Here total cost per film is given as $1.53, including an allowance of 75 cents for reading films, but excluding rent, maintenance, utilities and main office administrative costs. Several factors make the Rev. Mr. Schmeuszer's per film cost of routine chest x-ray come out somewhat higher than those of Dr. Morgan's: One is his assumption that the tube will last for only 10,000 exposures (as against 20,000 estimated by Dr. Morgan). Another is the fact that he depreciates the x-ray equipment over eight years instead of 10 years. Also, he allows for a reading charge of 75 cents per film, instead of 50 cents as does Dr. Morgan.

The films taken are 4 by 10 inch stereos, which of course increases film and processing costs beyond those encountered where single 4 by 5 inch films are taken.

In the last analysis, the fiscal experience of any hospital in this field will differ from that of any other hospital, and each one must make its own accounting study to determine what its cost will be. The only suggestion I would make is that the following factors *all* be taken into account to assure a true picture: (1) Amortization of capital equipment over a period that corresponds with the expected life of the equipment. Be careful to separate that portion of the equipment used exclusively for routine chest examinations from that which is used only partially for this purpose, and charge the routine chest program only with its pro rata share of depreciation cost. (2) Service charges, based on past experience. (3) Films, developing chemicals and other accessories required for the program. (4) Personnel. (5) Value of floor space, unless it is space hitherto unused. (6) Utilities. (7) Tube replacement, based on the exposure-life rating of the tube. (8) Reading fees.

As for the equipment required to do the job, this will also vary, depending on the layout and present facilities of the hospital. There are four kinds of miniature-film screening cameras in common use today: 70 mm. single, 70 mm. stereo, 4 by 5 single, and 4 by 5 stereo. There are three kinds of installations. One is complete with camera, hood, tube, transformer, control and supply cabinets; a separate darkroom should rarely be necessary. Another, being located within 40 feet of the transformer of the radiology department, can obtain current from this transformer, but requires its own tube, in addition to the camera and hood, and so on. A third variety involves merely the acquisition of a camera and hood, inasmuch as it can be located in the radiology department proper, at one end of a room, so that the present tube, transformer and control can be used to generate the x-rays.

The basic cost of the capital equipment at present-day levels will range from $4500 for a 70 mm. single-frame camera and hood with viewer and developing hangers, but using existing darkroom facilities, to $11,200 for a complete 70 mm. stereoscopic setup, including generator and tube, a special roll film developing unit, viewer and drying rack. To acquire a 4 by 10 inch stereoscopic setup with viewer and developing hangers would entail an expenditure of slightly less than $10,000.

At Deaconess, in addition to its oft-cited values, the routine chest x-ray program has been found to "offer important findings for the teaching program of the hospital; to shorten the average hospital stay by detecting unsuspected lesions as quickly as possible; to provide control films that are extremely valuable for comparative purposes if and when future or subsequent films are obtained, and to protect other patients and hospital personnel from undue exposure," according to the Rev. Mr. Schmeuszer.

In the 110 hospital Wisconsin survey mentioned earlier, the average *cost* per film was somewhere between $1.50 and $2. The average *charge* was about $2. However, cost estimates ranged from a low of 30 cents per film for 70 mm. roll film and 50 cents per film for 4 by 10 stereo cut film, to a high estimate of $3.04 submitted by a hospital which uses only 14 by 17 inch films for this purpose. Charges in this survey ranged from 50 cents up to $5.

The variations in these figures arise from two causes: the nonuniformity in accounting procedures and the different types of x-ray equipment used. For this reason, it is more accurate to go by the figures compiled by Dr. Morgan on the basis of a uniform and all-inclusive accounting method and a stated type of x-ray equipment, allowing for all possible factors which are chargeable against the cost of the program.

In close agreement with the findings of Dr. Morgan, the Rev. Mr. Schmeuszer, and the Wisconsin survey are those of the U.S. Public Health Service in 1952, in which the per x-ray film cost for hospitals with under 100 beds (annual average admission of

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1500) is estimated at $1.32 and in hospitals with 250 beds and over (annual average admissions of 12,000) the per film cost drops to 98 cents.

A new wrinkle in the economics of routine chest x-ray has appeared with the possibility of renting rather than buying the basic x-ray equipment. The monthly charge ranges from $250 to $300, depending on the type of equipment used. The first known example of this method may be found at an eastern hospital (440 beds, 12,000 yearly admissions) whose equipment uses cut film 4 by 5 inches in size. The program is supported by the sale of Christmas seals. The experience at this institution is still too new to permit a detailed comparison of the economics of rental and purchase. However, it can be pointed out that, assuming a rental of $250 per month, a TB association must provide from its budget $3000 per year. If the hospital were to charge for its films at the rate of $2 (as it would if the program were not subsidized) it could expect an income of $24,000 per year, less the fees not collected from underage children, emergency cases, and other "misses." The "safety margin" here available for covering the added cost of possible darkroom accessories, also films, chemicals, space and reading fees, is more than adequate.

One advantage of rental is that, included in the monthly fee are many "hidden" charges otherwise borne by the hospital or association: (1) depreciation and depreciation reserve, (2) insurance, (3) interest on borrowed funds, (4) servicing costs, and (5) replacement parts costs, including tubes. Of these, the most important, of course, is depreciation. The worry of having to set aside enough funds to replace the equipment after it wears out or upgrading it when it becomes obsolescent is eliminated entirely, since this becomes the responsibility of the manufacturer.

Another worry — servicing — is not only shouldered by the manufacturer or dealer, but is also reduced in frequency, since the manufacturer has a "vested interest" in doing a job of preventive maintenance, thus reducing the number and frequency of breakdowns. Under the rental system, a sizable amount of cash is freed for use in other directions.

A most serious consideration in favor of establishing chest x-rays on a routine basis in all hospitals is the growing rate of malpractice suits. According to Louis J. Regan, M.D., LL.B., writing in the January 1952 issue of the *Wisconsin Medical Journal:* "The incidence of malpractice claims increased tenfold during the decade between 1930 and 1940. In some localities, malpractice claims have become so frequent that any patient with a less than perfect end result is a potential malpractice claimant. . . . There are a large number of malpractice actions in the law reports which may be classified as 'insufficient treatment cases' . . . failure to make a blood count, a Wassermann, a pregnancy test, a culture, a smear, a urinalysis, a stool examination, an x-ray, original or follow-up. . . . Failure to use the x-ray at all, or failure to make sufficient use of the x-ray, has been the chief allegation in many malpractice actions."

An even stronger expression on this score was the statement made by one medical member of a panel discussion sponsored in Chicago recently by the Tuberculosis Institute of Chicago and Cook County: "Failure to give routine x-rays on hospital admission should be considered medical negligence by the A.M.A."

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Unnecessary Use of Blood

(*Continued From Page* 58)

blood sufficiently frequently so that hepatitis transmission has been largely ruled out.

In many hospitals there are residents who are on the blood bank list and may be used as professional donors in such cases, provided they have given blood before to patients who have not developed hepatitis from their blood. This procedure will not prevent hepatitis entirely in these patients, but will reduce its occurrence to a minimum. In cases of liver damage, acute or chronic, an attack of hepatitis may well produce a fatal outcome.

In many medical patients, too many transfusions are given for anemia instead of these cases being treated with anti-anemic therapy. I always remember the late W. W. Herrick stating that unless the percentage of hemoglobin was below 50 per cent he did not recommend transfusion unless conservative anti-anemic treatment had failed, or an associated acute condition was also present.

The greatest abuse of transfusions occurs in surgery. All surgeons try preoperatively in elective cases to approach normal blood values. If hematocrit, hemoglobin and blood count determinations are too low, whole blood must be given before the patient can undergo surgery.

Such a patient with relatively normal blood values comes to surgery. If hypotension and/or a rapid pulse develops the anesthetist frequently asks if she can start the blood. The surgeon too often tells her to go ahead. Mind you, there is little or no loss of blood. The hypotension is a result possibly of preoperative sedation, too much or faulty anesthetic agents or administration, insufficient fluid intravenously, or abdominal manipulation, and other similar factors.

In this type of reaction without the problem of blood loss, before, during and after an operation, it would be more realistic to correct the cause of the hypotension. If this is not obvious or is impossible to do, intravenous glucose or saline may correct the situation. If this does not correct the problem and the hypotension is increasing, obviously other measures are required. If the surgical procedure is going to be long and complicated, requiring several units of blood, there is no call for delaying the use of blood. On the other hand, if such is not the case, I would consider using 500 cc. of a plasma expander such as dextran.[2] In many conditions this would make it unnecessary to use blood.

Let us assume that a well prepared patient with normal blood values loses three, four or five hundred cc. of blood. If the patient is not elderly and operative shock is not present, the patient may do very well without any transfusion. If hypotension should develop and progress, a plasma expander such as dextran may be used, at least while blood is being obtained. A decision can then be made when the blood is ready whether to give it during the remainder of the operation, in the recovery room, or not at all. Where possible it is better to give blood when a patient is not under anesthesia as severe reactions caused by misgrouping or other types of incompatibility are masked by the anesthesia.

Plasma volume expanders are being used more frequently all the time. They have been improved considerably in the past few years. They may be divided into four groups:

1. *Blood derivatives:* Albumen, plasma, modified globin. Albumen is expensive. Plasma is no longer used unless kept at room temperature for six months. Modified globin has been mixed with dextran to provide protein.

2. *Modified proteins:* Gelatin and oxy polygelatin have not proved satisfactory.

3. *Polymerized carbohydrates:* Dextran, a polysaccharide or a polymer of glucose. It is made by the action of an enzyme on sucrose. Its molecular weight is made to average 65,000 to 70,000, very similar to serum albumen. Particles with a molecular weight above 200,000 may be deposited in reticulo-endothelial cells. Those lower than 25,000 pass too quickly through the blood vessel walls to give an expander effect on the plasma volume.

[2]Dextran is a generic name which has been adopted by the A.M.A. Council on Pharmacy and by the Food and Drug Administration. There are several brands of dextran on the market under various names.

4. *Plastics:* Polyvinylpyrrolidine commonly called P.V.P., a synthesized product from acetylene and formaldehyde. Some of its proponents believe that P.V.P. will be the expander of choice in the future. It is relatively cheap to manufacture. Certain histological changes are reported in body tissues after infusions of P.V.P. This does not occur with dextran.

As a plasma expander dextran meets the requirements to a greater degree than any of those mentioned. Twenty-five to 40 per cent of dextran given intravenously is excreted in the urine in the first 24 hours. A large fraction of the total amount is metabolized and broken down as carbon dioxide. About 2 per cent is excreted in the feces.

Dextran is a clear stable solution, does not require refrigeration, is a 6 per cent solution in normal saline. The usual amount necessary is 500 cc. for adults, although considerably more may be given.

1. Dextran does not interfere with blood typing or cross-matching.
2. It remains in the body for a short period (10 days).
3. It increases and maintains plasma volume over a 24 hour period. Its greatest effect is seen during the first and second hour.
4. It is free from viral contamination and does not cause antigenecity.
5. Renal and hepatic functions are not affected by this substance.
6. Reactions can occur with dextran but are usually rare and not severe. They are characterized by moderate rise in temperature, urticaria and chilly sensations.

In giving blood or dextran to patients with an allergic history, pyribenzamine or benadryl may be given subcutaneously or intramuscularly at the start of the transfusion or infusion.

Dextran or similar solutions are not used ever as blood substitutes. When blood loss is severe nothing can replace whole blood. The use of blood in hospitals can be decreased by one-third if certain abuses in its routine use are corrected. By eliminating this waste, the critically short supply of blood may be increased so that more blood will be available for the armed forces, civilian use, and for gamma globulin and other blood fractions. In very severe conditions of surgical shock, without severe loss of blood, there is some evidence that dextran plus the use of blood gives better results than when either is used alone.

Conducted by Mary P. Huddleson

Centralized Tray Service

gets a high rating from the navy's new hospital

LT. O. R. SCHEILE, MSC USN
Commissary Officer
United States Naval Hospital, Corona, Calif.

THE first completely centralized tray service in a large naval hospital, with preparation of both regular and special diet trays on the same tray assembly line, has been achieved at the United States Naval Hospital, Corona, Calif.

This hospital, 40 miles southeast of Los Angeles, was activated on an emergency basis during World War II. A large hotel type of club building in the country four miles north of the town of Corona was purchased and converted to hospital use. A new ward building, eight stories in height, was connected to the original building by a long covered passageway.

PASSAGEWAYS CONNECT UNITS

The capacity of Unit No. 1 is 800 patients. Subsequently, at the base of the hill occupied by this unit, Unit No. 2 was constructed. The second unit is the typical — in military hospitals — series of one-story wooden structures connected by covered passageways and also has a capacity of 800 patients.

Unit No. 2 was reactivated in November 1951 on a temporary basis until the remodeling and reequipping of Unit No. 1 was completed. Meanwhile a study of the possibility of using the new thermal pack food service system to centralize tray service in Unit No. 1 was being made.

Use of bulk hot food carts, ward service kitchens, and decentralized tray assembly long has been customary in naval hospitals. The large size of these hospitals and the distance from the main galley to the wards have forced the use of the decentralized system as the only means of keeping food hot until it reached the patients.

SIZE, DISTANCE ARE PROBLEMS

Problems of both size and distance are emphasized in Unit No. 1 at Corona. Food carts leaving the main galley descend one floor in a freight elevator to reach the entrance to the long passageway, over an intervening road, from the original building to the added wing. In the wing, food carts must compete with hundreds of ambulatory patients in the eight-story building for the right of way on two elevators.

Service of special diet trays to bed patients under these conditions was an especially difficult problem. Attempts to keep small portions of various special diet foods in good condition in such an operation have never been satisfactory. Nor was it possible, with the necessary decentralized tray assembly, to exercise any significant degree of control over the assembly of special diet trays. Availability, on the wards, of foods for general diet patients often proved an irresistible temptation to young special diet patients.

When our studies indicated that the thermal pack equipment would make possible central tray assembly of special diet trays Capt. A. B. Chesser, MC USN, commanding officer of the hospital, approved a request to the bureau of medicine and surgery for permission to install the new equipment for central tray service to 225 special diet patients.

Permission was received from the bureau in time for installation of the equipment in the remodeled galley of Unit No. 1 prior to the reactivation of the unit early in July 1952.

Transfer of more than 500 patients from Unit No. 2 to Unit No. 1 was accomplished in one day. Breakfast was served from the Unit No. 2 galley and the noon meal was soup, salad and sandwiches for most patients.

FROM ONE MEAL TO NEXT

The meal that evening was a complete menu for all patients. We made the change from one food service system to another, as well as from one kitchen to another, for that meal.

All ambulatory patients eat in a central dining room after obtaining their trays in a cafeteria line. A separate cafeteria line, controlled by the dietitian, is established for special diet patients.

The central service equipment was adequate for service to all bed patients, regular as well as special diet. In planning the system we had provided for service of trays on the wards to ambulatory special diet patients to keep them away from the temptations of general diet foods in the dining hall. This eliminated the special line for these ambulatory patients.

Left: Container packing and tray assembly table "in action" at main kitchen of a 450 bed hospital. Special and general diets are portioned into containers from food pans set into eight electrically heated food wells. Right: Packed and closed containers move to tray assembly section.

After a brief training period in the afternoon with the representative of the equipment supplier, our people began the assembly of trays for the first time on a motorized conveyor belt that evening. Whereas 90 minutes were required for the preparation of 200 trays that first meal — actually a rapid rate for many hospitals — an assembly crew of nine people now assembles 300 trays in one hour with ease.

A further break with standard operating procedures in naval hospital galleys was made that first meal. Food preparation and tray assembly for regular and special diet patients customarily are kept completely separate in naval hospitals. In our new operation foods for all types of diets were brought to the one assembly table and trays were assembled in order of patients, whether on regular or special diet.

The dietitian, or one of her assistants, stands at the head of the assembly table with the patients' tray cards, presorted by wards into packs of 20 cards. The dietitian in this position controls the flow of operations on the line, as well as the portioning of the hot foods into the heated dish.

Cooks portion regular or special diet foods into each dish as called for by the dietitian. A tray card, indicating the patient's name, ward number and type of diet, goes down the line with each container and onto each tray.

DIFFERS FROM INDUSTRY

There is one point of major difference between the industrial assembly line and the hospital tray assembly line. The industrial line worker adds the same item to each piece of equipment as it moves down the line, whereas the hospital tray line worker must make a selection of the items before her for each tray as it passes by.

Our early experience reinforced our suspicions that workers would have difficulty in reading tray cards and reacting with the proper items before the trays passed each assembly station. The person who assembled the salads must select one from another with a minimum of delay, and place it on a tray. How could we best tell her what salad to put on what tray?

Standard 3 by 5 inch cards are used as tray cards for all regular diet patients. Each worker on the line knows that these cards, standard in shape and size, call for regular diet items on the tray. Long, narrow cards are used for special diet trays. The shape of the card warns the worker: "Be careful. This is a special diet tray!"

Rubber stamps, with type ½ inch high that is easily read at a distance of many feet even by those with poor eyesight, are used to designate the type of diet on each card. When the dietitian wishes to make out a tray card for a patient on a bland diet she merely picks up a card with "BLAND" stamped on it in big letters, writes the patient's name and ward number across the end (this information is of no interest to the worker on the line) and inserts the card in its proper place in the file of tray cards.

Cards are wrapped in used x-ray film to preserve them. On the ward each card is removed from the tray just before it is given to the patient and the card is placed in a box on the tray cart for return to the dietitian and sorting for the next meal.

Trays come off the 32 foot long assembly line complete except for beverage and soup. These are carried on the tray carts in large, accessible vacuum jugs and are served to the trays on the wards. This reduces to the irreducible minimum the work and the selection on the wards.

The day after the change from decentralized to centralized service was made, the commanding officer and the executive officer, both physicians, began a two-day series of personal interviews with patients in all parts of the hospital. They also interviewed nurses

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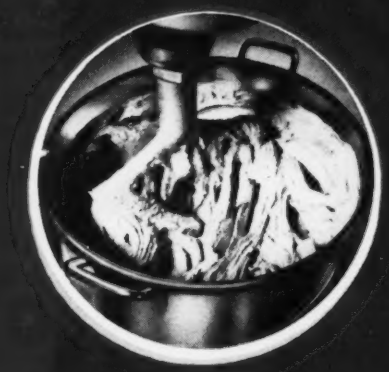

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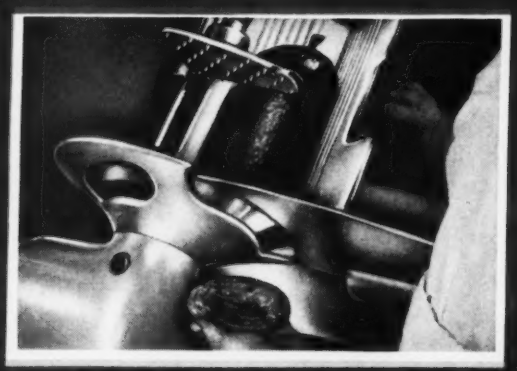

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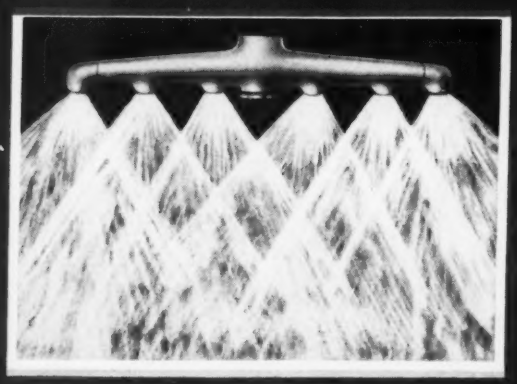

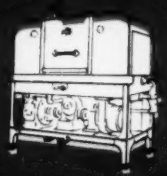

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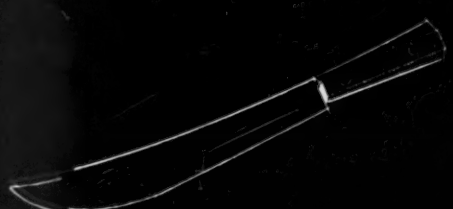

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and corpsmen and studied our operations in the galley.

On the fourth day of use of the system, following this intensive personal investigation, the commanding officer directed that our new system be expanded to serve up to 400 patients. Some of the extra equipment was necessary to provide service to the wards for females and infants, always a difficult section for the food service in any naval hospital owing to the smaller portions of food required for this type of patient. This is the section of the naval hospital that is most similar to the average civilian hospital.

Patients throughout the hospital have registered a strong preference for the new system. Their eating bears out their words. We have found a 40 per cent reduction in leftovers returned on the trays with the thermal pack system. This is due, in part, to the fact that the food stays hot all the while the patient is eating.

With the bulk carts patients could call for the types and amounts of food they wanted. They could get second helpings when they wanted them. There had been some concern over removal of these privileges. The commanding officer was not concerned. He said the navy's balanced ration consisted of plenty of food for a man at one meal and that we could make allowances in special cases if such action became necessary.

It has not been necessary. The patient now gets a balanced ration with all of the foods in appetizing condition. By the time he eats soup, the entrée, salad and dessert, he has lost interest in a second portion.

Doctors and nurses favor the new system over the old. The doctors like the fact that their patients enjoy the food more and special diets are adhered to. Nurses appreciate the decreased work on the wards.

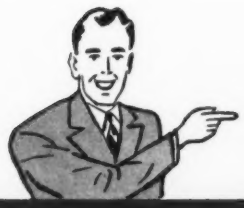
Because the foods for the cafeteria line and the tray assembly line come out of the same pots and ovens we cannot determine, exactly, the effect that centralized portioning controls have had on our food costs. The available evidence indicates, however, that we are saving at least 10 per cent on food costs.

The work load and time consumption of tray assembly have been shifted from nurses and corpsmen, a personnel area in which we are always shorthanded, to the more easily obtainable and less skilled people on the tray line in the main galley.

Training of culinary employes in a system with which none of them was at all familiar was far less of a problem than it might have been expected to be. The operation of a conveyor belt assembly table, while it seems complex in the whole, becomes simple when broken down into its component parts. By focusing the attention of each employe on the employe's immediate job sector we virtually eliminated the training "problem" after the first few days of operation.

The centralized system gives opportunity for planning, controls and exercise of the management function which does not exist with the decentralized service. The success of the system, of course, depends to a major extent on the degree to which advantage is taken of this opportunity.

On the basis of years of experience with decentralized service and eight months of experience with centralized service, we feel that all of the advantages lie with centralized service, provided, of course, that proper equipment is available, as it is to us, for keeping foods hot and palatable until they are consumed by the patients.



Questions and Answers about

COFFEE URNS with PERMANENT FILTERS

1. what is a permanent filter?

A self-contained metal unit requiring no urn bags or filter paper. Preferably it is made of stainless steel.

The Tri-Saver system eliminates urn bags and filter paper. Prevents spoiled batches due to torn filter paper or rancid urn bags.

2. what should I look for?

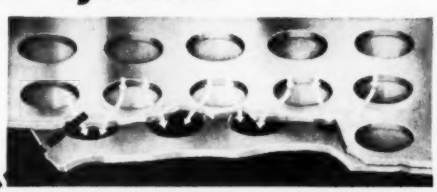
The filtering surface should be so constructed that coffee grounds do not clog it. This may happen if ordinary mesh or screen construction is used.

Ordinary mesh or screen surfaces trap coffee grounds, thus clogging the filter and making cleaning difficult. Flavor is affected.

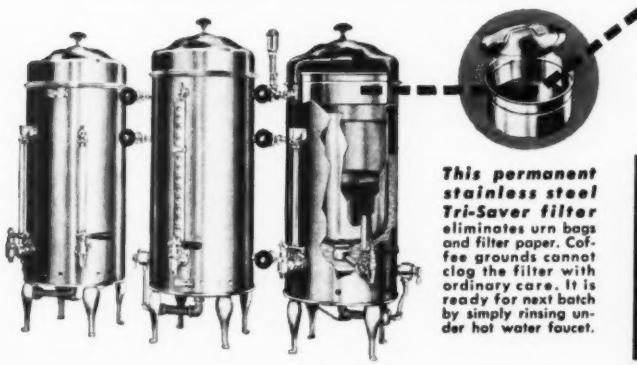
Tri-Saver filter has no holes *through* it. Surface appears solid—yet water and coffee liquid will pass thru rapidly.

3. what is the Tri-Saver Coffee System?

It is an improved method of brewing *consistently* full-flavored crystal-clear coffee without urn bags or filter paper. Urns employed in the Tri-Saver system use patented permanent stainless steel filters with specially-constructed bottoms. Thousands have been in use for years, never clog, remain sweet and clean with ordinary care.



Cutaway view showing specially-constructed bottom of Tri-Saver filter. Filtering surface consists of two precision-perforated stainless steel plates welded together. The coffee liquid passes through holes in upper plate, then *edgewise* by capillary attraction into the holes of the lower plate and then into the liner below. Only the clear coffee brew with all the essential flavoring matter gets through. Rinsing provides *thorough* flushing by the same capillary action.



This permanent stainless steel Tri-Saver filter eliminates urn bags and filter paper. Coffee grounds cannot clog the filter with ordinary care. It is ready for next batch by simply rinsing under hot water faucet.

SEND FOR TRI-SAVER BOOK

Gives full story of Tri-Saver Coffee System. Shows complete line of single urns, batteries, twin, combination and institution urns, in capacities from 3 to 80 gallons. Available for gas, steam or electric heat.

S. Blickman, Inc., 1502 Gregory Ave., Weehawken, N. J.

LOOK FOR THE TRI-SAVER NAME-PLATE—YOUR PROTECTION AGAINST INFERIOR SUBSTITUTES

Blickman-Built
FOOD SERVICE EQUIPMENT
EST 1889

You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass. March 29-31

Cost Control Technics

are an aid to good judgment

MARY M. HARRINGTON

Assistant Director and
Director of Dietetics, Harper Hospital, Detroit

COST control technics are valuable tools but do not replace sound judgment. The methods of food cost accounting vary greatly in hospitals and may be more detailed in the larger institutions. Detailed food cost accounting is extravagant if the information acquired is not used as a guide to cost control and efficient management of the department.

An accurate method of cost finding permits a detailed study of all disbursements, the unit cost of various articles of food and supplies, the cost of processing food, and the cost of feeding patients and personnel. It will enable the dietitian to give the patients and personnel the quality of food and service at a desired level with a minimum cost.

Control starts with the use of a master menu. A schedule can be planned for a given period of time, with the meats and desserts listed. This assures the use of the more expensive items a specified number of times over a definite period. The master menu should be written at least 10 days in advance and vegetables and fruits should be selected according to the market conditions.

The cafeteria menu should be planned to use the foods on the master menu as far as possible, with additional foods if an increased number of items is being offered. These additional items can be listed for the unit kitchen dietitians to use in making substitutions in accordance with the likes and dislikes of patients. Such a procedure serves to control the number of foods which have to be prepared and gives uniformity to all serving units.

The therapeutic diets are made up from the master menu and are modifications of the house menu. If spinach is on that menu, some of it can be saved for the low sodium diets before salt is added. More may be saved for the low fat diets before fat is added. Such a procedure reduces the labor in preparation and increases patient satisfaction on the wards, since there is uniformity in the foods being served to patients on the various diets. Actually, this illustrates what is meant by the practice of considering the therapeutic diet as a modification of the house diet.

Forms can be developed to reduce writing and to serve as controls. The specifications for meats and so forth would not need to be written each time. The purchasing department can obtain quotations from suppliers once a week and decide where the order will be placed, but should have no authority to change any specifications. A similar plan can be used to obtain daily price quotations on fresh produce and this information is given to the dietitian. The dietitian writes the requisition for the meat and fresh produce on a standard requisition form used by the purchasing department. If meat and fresh produce are delivered directly to the main kitchen, the invoice should come with these supplies and be used in computing portion costs and daily food costs. New articles

28 DAY MASTER MENU

	SEMIPRIVATE		PRIVATE	
	Luncheon	*Dinner*	*Luncheon*	*Dinner*
M.	Corned beef hash	Meat loaf	Mushroom à la king with patties	Beef à la mode
T.	Deviled egg or lamb stew, vegetables	Roast veal	Deviled eggs	Lamb chops
W.	Meat pie	Beef à la mode	Assorted cheese	Tenderloin steak
T.	Turkey goulash	Roast fresh ham	Vegetable casserole	Roast fresh ham
F.	Salmon loaf with tomato sauce	Broiled halibut	Salmon salad	Broiled halibut
S.	Vegetable plate	Swiss steak	Vegetable omelet	Roast lamb
S.	Spaghetti with tomato sauce or macaroni au gratin	Beef à la mode	Spaghetti with tomato sauce or macaroni au gratin	Roast chicken with dressing
M.	Hamburgers	Veal cutlets	Asparagus on toast with cheese sauce	Cube steak on toast
T.	Liver and bacon	Roast beef	Sandwiches	Roast beef
W.	Vegetable omelet	Meat loaf	Fruit salad	Lamb chops
T.	Italienne spaghetti	Corned beef	Welsh rabbit on toast	Veal cutlet
F.	Codfish cakes with creamed peas	Fillet of sole	Salmon and noodle casserole	Fillet of sole
S.	Salisbury steak	Roast veal	Vegetable plate	Cube steak on toast
S.	Meat and American cheese	Chicken pie	Tomato stuffed with cottage cheese or vegetable salad	Chicken pie
M.	Creamed chip beef on melba	Beef à la mode	Chicken liver omelet	Beef à la mode
T.	Ground bologna or bologna and liverwurst	Roast lamb	Mushrooms à la king with patties	Roast lamb
W.	Swiss steak	Roast fresh ham	Cold roast beef and American cheese	Roast fresh ham
T.	Spanish omelet	Beef roll	Spanish omelet	Beef roll
F.	Salmon loaf with tomato sauce	Steamed halibut with sauce	Sandwiches	Steamed halibut with sauce
S.	Shepherd's pie	Beef à la mode	Fruit salad	Roast veal
S.	Chipped beef à la mode on melba	Roast beef	Chipped beef à la mode on melba	Chicken Maryland
M.	Chop suey with buttered rice	Veal birds	Sandwiches	Roast beef
T.	Spaghetti with tomatoes	Baked fresh ham	Chicken vegetable salad	Tenderloin steaks
W.	Corned beef hash	Roast lamb	Ham scallop	Lamb chops
T.	Spanish rice	Roast veal	Chef's salad	Veal birds
F.	Codfish cakes with creamed eggs	Fillet of sole	Salmon loaf with creamed peas	Fillet of sole
S.	Hamburgers	Baked pork chops	Vegetable casserole	Baked pork chops
S.	Cold roast beef	Cube steak on toast	Toasted bacon and tomato with cheese sauce	Roast chicken with dressing

of food should not be added to stores without serious consideration of their need, if we are to avoid an expensive inventory of slow moving stock. Such additions should be approved by the administration.

The requisition form for staples can be planned to control the minimum unit which can be ordered, thereby reducing packaging by stores. Such forms also serve as a check list for the dietitian. Requisitions can be sent to the inventory control department for pricing. Nothing should be sent out from the main kitchen without a written requisition. An interdepartmental requisition is used to control the number of items or amounts of special orders requested by the serving or unit kitchens and cafeterias. All requisitions for repairs should be checked by the dietitian as it is sometimes less expensive to replace than it is to repair where labor costs are high.

It is necessary to make note of food costs daily and these computations can be made by a dietary clerk. This information can be cumulative so that a food statistics report will be available at the end of the month. Such records show the amounts of the various items purchased and the total amount of money spent for each. A relationship drawn between the quantities of food used and meals served serves as a useful index. For example, a marked increase in the amount of beef "used" per meal revealed a leak in the meat shop. The relationship of quantity per meal is not important in itself, but in monthly comparisons this serves as important information since it shows trends in quantities of food being used. Standardized recipes must be used and priced at regular intervals, but adjustments have to be made immediately if there is a major price increase in order to ensure control of costs. Planning is an essential element of cost control. What recipe is to be used must be specified and most certainly the major responsibility cannot be left to the cooks. A written schedule of the foods to be prepared, and the amounts to be used by individual cooks, reduces the volume of leftovers. This also reduces effort as duties are clearly outlined. It is equally necessary to specify in writing the amount of each vegetable to be prepared. Standards in writing must be furnished the salad room to assure control of portions and quantity to be prepared. Such decisions cannot be left to the workers' judgment if uniformity and control are to be preserved.

Portion control is necessary in regulating costs. Control in preparation is assured by the use of scales. Control of cooking temperatures will reduce the shrinkage of meat, and yield tests must be made at intervals to determine costs. (A study of a 7½ pound and a 9 pound leg of lamb showed that a 50 gm. portion cost 0.221 cent from the smaller, and 0.223 from the larger, which is not considered significant.) Portions can be controlled by proper selection of the size of the dish in which the food is to be served. Frequent samplings by weight during the cutting of raw or cooked meat reduce wide variations in the size of portions. Use of a scale for testing the overflow and packaging of ice cream in 3 ounce cups helps to maintain uniformity in the size of portions. Use of a divider in filling these cups reduces time required, thus reduces labor costs. Buying coffee in 12 ounce instead of 1 pound packages saved 12 ounces per 8 gallons of coffee. Use of fluted paper cups for muffins and cupcakes aids in controlling the size. Innumerable technics of a similar type could be cited for portion control.

Records should be further developed when more information is needed to provide better cost control. A cost analysis provided by the accounting department monthly gives a clear picture of control. When the cost varies a study should be made at once to see *why* it varies. When an increase in replacement cost of dishes and silver was studied it was found that replacement had actually decreased, but the cost of the items had increased markedly.

Sampling of man-hour meal ratios will give some index of the efficient use, or at least a trend in the use of labor.

The use of charge slips for special items other than meals serves as a control and prevents many special orders, especially when the patient realizes they are charged on his hospital bill.

Close supervision daily of the storeroom and refrigerators prevents loss. These should be kept locked when supervision is not available. Low inventories should be maintained so that loss may be easily detected.

The American Hospital Association manual of food cost accounting lists the raw food cost as 54 per cent of the money spent by the dietetic department. This is about 8 per cent higher than the figures in our institution.

any time of day . . .

a CITRUS SNACK

is a welcome "pick-up"

Delicious citrus snacks appease between-meals hunger, provide quick energy, and promote sound nutrition. They help obese patients by reducing their desire for high-calorie foods. Encouraging the citrus snack habit is a most excellent and pleasant means of insuring an adequate intake of vitamin C daily.

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Nell M. Joyce
Food Service Manager
Davis Hospital
Pine Bluff, Ark.

Menus for March 1954

1 Pineapple Juice Scrambled Eggs, Bacon • Potato Soup Hamburger Steaks Tomato Gravy Escalloped Potatoes Broiled Peach Halves Chocolate Pie • Mixed Juice Cocktail Turkey Croquettes with Cream Sauce Spinach With Egg Slices and Lemon Buttered Yellow Corn Apple Crunch, Cream	**2** Grapefruit Half Poached Eggs, Muffins • Cream of Green Pea Soup Fried Chicken, Gravy Whipped Potatoes Buttered Carrots Hot Rolls, Preserves Sliced Tomato, Mayonnaise Orange Gelatin Cubes With Custard • Beef Noodle Soup Cheese Soufflé, Bacon Hashed Brown Potatoes Buttered Broccoli Fruit Salad, Cookies	**3** Orange Juice Scrambled Eggs, Bacon • Cream of Tomato Soup Baked Ham Turnip Greens Baked Potatoes Corn Bread Apple Pie à la Mode • Chicken Rice Soup Hamburger Steaks Green Beans Escalloped Potatoes Lime Gelatin Salad With Cucumber and Celery Pears and Brownies	**4** Apple Juice Soft Cooked Eggs, Ham • Mushroom Broth Broiled Steaks Potatoes au Gratin Spinach, Sliced Egg and Vinegar Carrot Sticks Parker House Rolls Lemon Chiffon Pie • Consommé Baked Pork Chops Seasoned Hominy Okra Sliced Tomato Peach Half, Macaroon	**5** Kadota Figs Scrambled Eggs, Toast • Noodle Soup Tuna Croquettes With Parsley Sauce English Peas Baked Idaho Potatoes Toasted Rusk, Jelly Orange Salad With Mayonnaise • Vegetable Soup Scrambled Eggs Hot Biscuits Lettuce Wedge, 1000 Island Dressing Apricot Whip	**6** Mixed Juices Poached Eggs, Bacon • Bouillon Spareribs, Barbecue Sauce Baked Beans Baked Apple Quarters Cranberry Salad • Celery Soup Chicken Livers and Gizzards on Rice Tomato Stuffed With Cottage Cheese, Green Pepper, Cucumber, Celery, Onion Cold Baked Custard
7 Grapefruit Half Scrambled Eggs, Sausages • Mixed Juice Cocktail Veal Cutlets Lady Peas Harvard Beets Perfection Salad Butterscotch Pie With Whipped Cream • Bouillon Fricassee of Chicken Buttered Carrots Broiled Tomatoes Molded Chunk Pineapple in Lime Gelatin Fudge Iced Sheet Cake	**8** Orange Juice Poached Eggs, Bacon • Beef Noodle Soup Small Broiled Steaks Green Beans Potatoes Tossed Vegetable Salad With French Dressing Apple Pie à la Mode • Cream of Tomato Soup Hamburger Steaks Escalloped Potatoes Cucumber, Celery, Green Pepper in Lemon Mold Cocoanut Cake	**9** Pineapple Juice Scrambled Eggs, Toast • Chicken Rice Soup Calves Liver, Bacon Buttered Rice Buttered Asparagus Lettuce Wedge, 1000 Island Dressing Pears and Brownies • Vegetable Soup Baked Pork Chops Buttered Green Beans Turnip Greens Sliced Tomatoes Blackberry Pie	**10** Stewed Prunes Soft Cooked Eggs, Roll • Cream of Asparagus Soup Fried Chicken, Gravy Whipped Potatoes Okra Sunset Salad With Mayonnaise Cocoanut Cake • Beef Noodle Soup Cheese Soufflé, Bacon Buttered Green Beans Broiled Tomatoes Celery, Olives on Lettuce Hot Baked Apple, Cream	**11** Apple Juice Poached Eggs, Ham • Tomato Bisque Spareribs, Barbecue Sauce Baked Potatoes Turnip Greens Lettuce Wedge With French Dressing Hot Apricot Cobbler • Potato Soup Turkey Croquettes English Peas With Cream Sauce Toasted Rusk, Marmalade Strawberries With Cream	**12** Mixed Juices Scrambled Eggs, Roll • Cream of Celery Soup Fried Oysters Buttered Corn Broccoli, Cheese Sauce Stuffed Tomato Chilled Pears • Cream of Tomato Soup Buttered Grits Buttered Spinach, Sliced Egg and Vinegar Doughnuts, Applesauce
13 Kadota Figs Scrambled Eggs, Ham • Vegetable Soup Swiss Steak, Onions Celery and Peppers Whipped Potatoes Green Beans Sliced Pineapple Tossed Vegetable Salad • Cream of Corn Soup Pork Sausage Baked Apple Quarters Green Peas Pear and Cheese Salad Sponge Cake	**14** Apricot Nectar Poached Eggs, Bacon • Consommé Fried Chicken, Gravy Rice Spinach, Sliced Eggs and Vinegar Olives Fruit Salad • Mushroom Soup Broiled Steaks Whipped Potatoes Buttered Asparagus Pickles and Spiced Beets on Lettuce White Iced Cake	**15** Pineapple Juice Scrambled Eggs, Ham • Pea Soup Meat Balls and Spaghetti Green Beans Mixed Vegetable Salad, French Dressing Apple Pie à la Mode • Cream of Asparagus Soup Sausage and Scrambled Eggs Broiled Tomatoes Pear Half and Cottage Cheese on Lettuce	**16** Applesauce Soft Cooked Eggs, Ham • Tomato Bouillon Smothered Calves Liver Boiled Potatoes Harvard Beets Pineapple Cheese Salad Cherry Tarts • Swiss Steak Baked Stuffed Potato Spinach, Sliced Eggs and Lemon Carrot Sticks and Pickles Damson Plum Preserves	**17** Stewed Prunes Scrambled Eggs, Bacon • Beef Broth Baked Ham Slices Potato Salad Celery Hearts Corn Bread Mixed Fruit Juice With Lime Ice • Fried Chicken Whipped Potatoes Buttered Broccoli Molded Fruit Salad Shamrock Cookies	**18** Orange Juice Poached Eggs, Bacon • Chicken Noodle Soup Steak, Gravy Baked Potato Brussels Sprouts Sliced Tomato With French Dressing Lemon Sponge Pudding • Baked Pork Chops Green Beans Parsley Potatoes Coleslaw Corn Bread Cherry Pie
19 Grape Juice Scrambled Eggs, Muffins • Tomato Juice Fillets of Cat Fish Tartare Sauce Creamed Potatoes Cucumber, Onion Salad Corn Bread Lemon Chiffon Pie • Salmon Croquettes Buttered Corn Assorted Relishes Hot Muffins Broiled Pears Sheet Cake, White Icing	**20** Prune Juice Soft Cooked Egg, Bacon • Celery Soup Beef Stew Corn Bread Lettuce Wedge, 1000 Island Dressing Peaches and Cream • Chicken à la King on Rusk Squash Sliced Tomatoes with French Dressing Chocolate Pie	**21** Grapefruit Half Scrambled Eggs, Bacon • Vegetable Soup Fried Chicken Baby Lima Beans Escalloped Egg Plant Hot Rolls Pear and Cottage Cheese Salad Chess Pie • Breaded Veal Cutlets Cauliflower, Cheese Sauce Green Beans Strawberry Shortcake	**22** Kadota Figs Poached Eggs, Ham • Onion Soup Calves Liver Baked Idaho Potato Brussels Sprouts Tossed Vegetable Salad With French Dressing Apple Pie á la Mode • Meat Loaf, Mushroom Sauce Escalloped Potatoes Broiled Tomatoes Pickles and Celery Chocolate Pie	**23** Orange Juice Baked Eggs, Bacon • French Onion Soup Baked Ham Purple Hull Peas Turnip Greens Corn Bread Sliced Tomatoes Lemon Sponge Pudding • Fried Chicken, Gravy Whipped Potatoes Buttered Carrots Vegetable Salad With French Dressing Hot Rolls With Peach Preserves	**24** Tomato Juice Scrambled Eggs, Ham • Potato Soup Stuffed Peppers Lady Peas Tomato and Cucumber With French Dressing Apricot Cobbler à la Mode • Baked Ham Turnip Greens Baked Sweet Potatoes Corn Bread Cabbage Salad Apple Crisp
25 Orange Sections Poached Eggs, Bacon • Bouillon Fried Chicken, Gravy Rice Buttered Broccoli With Cheese Sauce Pineapple and Date Salad Pecan Ice Cream • Breaded Veal Cutlets Creamed Potatoes Buttered Spinach Corn Bread Chef Salad Lemon Chiffon Pie	**26** Pineapple Juice Soft Cooked Eggs, Toast • Vegetable Bisque Halibut Steak Lady Peas Seasoned Cabbage Corn Bread Sliced Tomato, Cucumber, Onion With Mayonnaise Chocolate Cake • Tuna Croquettes With Mushroom Sauce Buttered Carrots Brussels Sprouts Fruit Salad Cold Baked Custard	**27** Grape Juice Scrambled Eggs, Bacon • Chicken Noodle Soup Fried Steak, Gravy Whipped Potatoes Beets Chow Chow Peach Whip • Spareribs, Barbecue Sauce Baked Potatoes Kraut Corn Bread Apple-Celery Salad Lemon Sponge Pudding	**28** Grapefruit Half Poached Eggs, Bacon • Consommé Breaded Veal Cutlets Cauliflower With Cheese Sauce Green Beans Strawberries With Cream • Bouillon Baked Hen With Dressing Buttered Asparagus Hot Rolls Carrot and Celery Sticks Fruit Salad	**29** Kadota Figs Scrambled Eggs, Bacon • Bouillon Baked Pork Chops Cabbage Corn Bread Sliced Tomatoes Apple Cobbler With Cream • Chicken Rice Soup Meat Loaf Escalloped Potatoes Buttered Spinach Sliced Cucumbers Peach Half With Sheet Cake	**30** Orange Juice Eggs, Broiled Ham • Vegetable Soup Veal Cutlets Whipped Potatoes Buttered Asparagus Wilted Lettuce Banana Cream Pie • Cheese Soufflé, Bacon Seasoned Green Beans With Potatoes Tomato and Cucumber Salad Apricot Cobbler With Cream

31 Apricot Nectar, Scrambled Eggs, Bacon • Grapefruit Juice, Baked Hen and Dressing, Creamed English Peas, Buttered Cauliflower, Hot Rolls, Celery Sticks, Cold Baked Custard • Sausage, Seasoned Hominy, Spinach With Egg Slices, Sliced Tomatoes, Hot Rolls, Sweet Potato Pie

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Another New IDEAL Food Conveyor...

The IDEAL DIET-THERM

A completely equipped portable food conveyor—just like the big Ideal Conveyors—but small, compact, low-priced. Ideal Diet-Therm is a unit of almost infinitely varied utility—ready to serve special diets and hot meals anywhere, anytime.

This Ideal unit is designed to facilitate the serving of special diets needed in emergency feeding operations—also for delayed servings and hot buffet lunches and snacks. It has its own heating element, its own complete control system, its own thermostatic equipment. It is a complete independent unit.

The food wells will accommodate any desired combination of standard steam table full size and fractional size pans. It can be equipped with 2″ or 4″ (deep) pans. There are 39 possible combinations. Ideal Diet-Therm can be removed from its stand and transported on top of any other food conveyor or portable unit. Write for complete specification data.

DESIGNED TO MEET A SPECIFIC NEED

Ideal Diet-Therm was developed by Ideal engineers for the Veterans Administration. It has amply proved its great usefulness. It brings a new and valuable aid to nutritional therapy.

OTHER IDEAL PRODUCTS IDEAL FOOD CONVEYORS IN A WIDE VARIETY OF STANDARD MODELS...IDEAL TERMINAL STERILIZER...IDEAL HOT PACK HEATER...IDEAL DIET-THERM...IDEAL THERMO-MIST MOIST HEAT THERAPY UNIT... IDEAL SPECIAL DIET TRAYS

◄ Showing Diet-Therm carried on Ideal Food Conveyor Model 1062

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HOSPITAL EQUIPMENT
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ESTABLISHED IN 1884
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HIA HOSPITAL INDUSTRIES ASSOCIATION

WRITE FOR CATALOG AND COMPLETE DATA

Lint, Linens and Laundry Planning

VICTOR KRAMER
Laundry Management Consultant
New York City

SOMETIMES the solution to a difficult laundry problem is not found in the laundry at all. It is found in the basic area of laundry planning—the utilization, for example, of a plant's hidden ability to solve its own problems. There is such a thing.

Many a laundry plant is alive with machinery but stagnant when it comes to planning. Some are staffed with loyal workers but fail to respond to peak demands; they lack the flexibility that planning puts into a plant.

In many cases, the laundry is practically on the verge of doing a twice-better job. It will probably never do it. It will continue on the verge, its real potential unrealized.

Whose job is laundry planning? Whose job is it to make a careful study of the whole laundry operation in terms of its over-all service potential? Whose job is it in your hospital? These are serious and fair questions because they directly affect the efficiency of the hospital as a whole.

Here is a case in point. A year ago, the New York Foundling Hospital's laundry was processing a volume of approximately 290,000 pieces a month. It had 13 employes who worked six days a week.

Was it an efficient laundry? By all appearances, yes. There were no serious complaints, no expensive breakdowns, no really big problems.

Today the laundry is processing 350,000 pieces a month, a 20 per cent increase, with *the same number* of employes working *only five days* a week for a total of 40 hours. Saturday and Sunday the plant is closed.

Moreover, linen storage and distribution have been simplified, the movement of soiled linen has been contained to a small area, washroom efficiency has been increased, and a linen storage room literally has been created out of waste space, permitting valuable extra space for other purposes.

What's more, the plant has acquired a production leverage. Now, Laundry Manager John Lyons can handle peak volumes without upset of employe or production schedules.

Laundry planning, not magic, did the trick.

To begin with, Stanley Turkel, account executive of a laundry management consulting firm, made a study of the plant's volume: 85 per cent was tumbled work (diapers, bed pads, towels); 12 per cent was flatwork (sheets, pillow cases); only 3 per cent was press work (uniforms, aprons, dresses). The tumblers were kept in operation six days a week on an average of 11 hours each day in order to handle the unusually large load of tumbled work.

Why so much tumbled work? The *babies:* diapers, rompers, panties, and more diapers.

Since 1869, the New York Foundling Hospital has been "a home for the little homeless." Operated by the Sisters of Charity under the direction of Rt. Rev. Msgr. John E. Reilly, no one

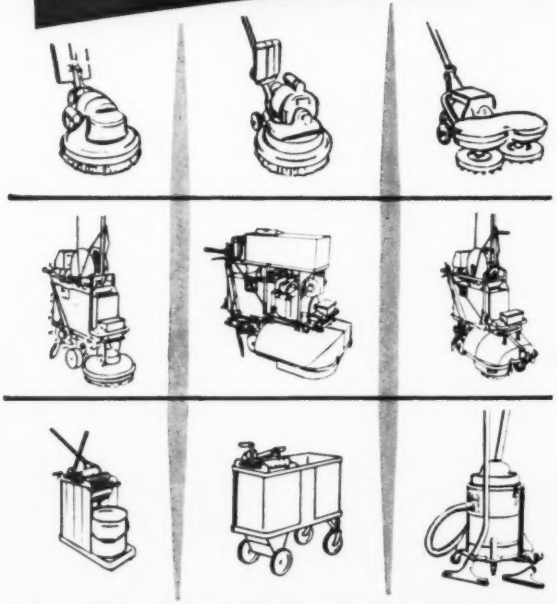
Left: The master lint trap is 17½ feet long and 5 feet high, with a 3 foot door that permits of easy access. Right: The new linen room.

Keep your floor-maintenance men happy . . .

with *Job-Fitted* EQUIPMENT!

Choose from the COMPLETE *Finnell* Line

More than a score of models and sizes permits selection of the equipment that's exactly right for your job!



However much a maintenance man may want to do a good job, and at the same time show savings in labor costs, he's *stymied* if the machine is too small, or too large, or is otherwise unsuited to the job. Different floors and areas call for different care and equipment. That's why *Finnell makes more than a score of floor-maintenance machines.* From this complete line, it is possible to choose equipment that is correct in size as well as model . . . that provides the maximum brush coverage consistent with the area and arrangement of the floors.

Finnell makes *Conventional Polishing-Scrubbing Machines* in both concentrated and divided-weight types, each in a full range of sizes . . . a *Dry-Scrubber*, with self-sharpening brushes, for cleaning grease-caked floors . . . *Combination Scrubber-Vac Machines* for small, vast, and intermediate operations, including gasoline as well as electric models . . . *Mop Trucks* . . . *Vacuum Cleaners* for wet and dry pick-up, including a model with By-Pass Motor. In addition, *Finnell* makes a full line of fast-acting *Cleansers* for machine-scrubbing . . . *Sealers* and *Waxes* of every requisite type . . . *Steel-Wool Pads*, and other accessories — *everything for floor care!*

In keeping with the *Finnell* policy of rendering an individualized service, *Finnell maintains a nation-wide staff of floor specialists and engineers. There's a Finnell man near you* to help solve your particular floor-maintenance problems . . . to train your operators in the proper use of *Finnell Job-Fitted Equipment and Supplies* . . . and to make periodic check-ups. For consultation, demonstration, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1402 East St., Elkhart, Ind. Branch Offices in all principal cities of the United States and Canada.

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything FINNELL for Floor Care

BRANCHES IN ALL PRINCIPAL CITIES

asks if the baby is white or black, Catholic, Protestant or Jewish. If the baby has no mother's care it is welcome here. The turnover is constant; the standards of service are high. Children are placed in boarding and adoptive homes by professional social workers and Sisters. During their stay at the hospital, the babies are dressed and given the same care as happy, well protected children receive in their own homes. Thus the laundry must deliver huge quantities of babies' work daily; so tumbled work is the laundry's heaviest load.

The plant had four tumblers (three 36 inch by 30 inch and one old 36 inch by 48 inch). Enough machines, apparently, yet why the bottleneck? Mr. Turkel found: back pressure, a choked lint trap, lack of time controls, low steam pressure, one obsolete machine.

The hot dry air from the tumblers was being vented into a small lint trap which filled up in a few minutes and forced moist air back into the machines. This choke-up prolonged the drying cycle.

MASTER LINT TRAP

A new master lint trap was built and installed. It is unique in several respects. Constructed by Peter McCabe and Patrick Hughes, maintenance engineers of the hospital, from plans drawn by the laundry consultants, it is actually a screened area (¼ inch screening overlapping ⅛ inch, 17½ feet long and 5 feet high) located directly outside the laundry building. Four 10 inch individual ducts, one from each tumbler, are vented into it through the laundry wall. A 3 foot wide door at one end permits easy access to the interior. The lint trap is easily cleaned once daily by specially installed air and water lines, which were brought through the wall. The operator merely wets the floor, knocks down accumulated lint, and sweeps out saturated lint.

The new trap allows vented hot air to escape quickly as it should. Back draft of moist air has been eliminated. Result? Drying time is speeded up, operational hours are cut, bottleneck is relieved. Since the trap adjoins a children's play area, a brick wall was erected to hide it from view. The simplicity of the installation belies its importance. To New York Foundling Hospital, it represents low cost, high level efficiency.

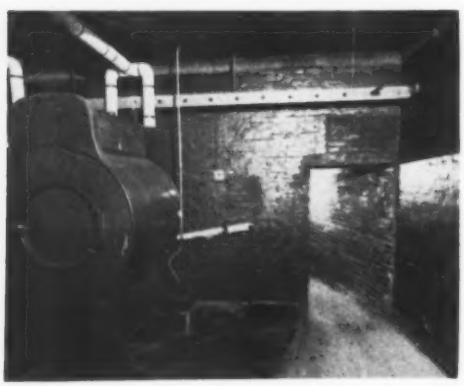
But the trap was only one phase of the problem. Other corrective action was needed.

When you operate an obsolete machine, you are paying for a new one but lacking it. So the old 36 by 48 inch tumbler was discarded and replaced by a new, open end 42 by 42 inch tumbler with capacity of 100 pounds per load. All four tumblers were then equipped with automatic temperature signals (a buzzer sounds and a light flashes to indicate the load is dry). That stopped the guesswork and prevented overdrying.

Then, to save man-hours, all four tumblers were relocated nearer to the washroom.

Finally, steam pressure at 100 pounds per square inch was assured by the installation of a new 4 inch steam line. Inadequate steam pressure was recognized as a production detriment.

To obtain fast tumbler results—to do the 66 hour job in 40 hours—to save hospital dollars required *planning*, evaluating, then coordinated action by all concerned. The tumbling department of New York Foundling Hospital's laundry now does a fine job at low cost. Schedules are promptly met; the plant is free of lint.



Linen distribution was speeded by the construction of a tunnel connecting the laundry with the new linen room so that linen can be trucked to and fro on one level.

LINEN DISTRIBUTION

Sorting, storing, classifying and distributing linens—from soiled to clean—create problems in every hospital laundry. Linen handling methods become obsolete owing to physical changes in buildings and layout, and the encroachment of space needs. At New York Foundling Hospital, an undesirable situation had developed. Soiled linen from many sources was trucked across a yard area, down a ramp, left standing adjacent to the laundry awaiting its turn in the plant. On Monday morning, particularly, it presented an unwelcome sight.

How could the linen be handled to eliminate moving and storing in the out-of-doors? Careful planning gave us the answer; Sister Thomas Regina gave us the green light; the maintenance engineers gave us the finished result. Two rooms in the basement of the St. John's building, which adjoins the laundry building, were converted into a modern linen department. Freshly painted, brightly lighted, fan ventilated, two dreary basement spaces were modernized for efficient handling of soiled and clean linens. A neat, simple tunnel was cut through connecting the laundry with the linen room so that the work is trucked to and fro on one level with ease, and that was that.

The outside area formerly used for soiled linen storage has become an additional playground space for children. The former linen room has now become productive hospital space and the laundry controls linen movement within the physical confines of its own building—through the tunnel to the two newly developed basement rooms. Linen distribution goes smoothly and the linen control system, with its regular inventories, par requirements, and so on, now really works.

Here we have told a few simple facts, how they were evaluated, what New York Foundling Hospital did about them. They are the kind of facts which don't show up on a production report — they are laundry planning facts which are hidden in every hospital laundry. When the facts are investigated and analyzed, it is easy to bring to life the hidden portion of existing laundry facilities.

Put together one way, the facts add up to the same little laundry crew working only five days instead of six, and producing 20 per cent more volume. Put together another way, they add up to the extreme importance of laundry planning.

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Conducted by Alta M. La Belle and Jane Barton

The V. A. Sets Up Housekeeping

TRAINING MANUAL ON WAXING—III

FOUR Housekeeping Training Guides, covering sweeping, mopping, dusting and waxing, have been developed by the Veterans Administration for use in its hospitals. In this issue The MODERN HOSPITAL presents the third section of the manual on waxing. The manuals on sweeping, mopping and dusting have been presented in successive months, beginning in the January 1953 issue of this magazine.—ED.

63. Waxey's term for performing a thorough cleaning and re-waxing job is "to give it the works." This term implies that he has to perform every operation starting with "clearing the deck" to the end polishing job.

Let's see how Waxey "gives it the works."

64. The object lesson in this drawing is first to move every possible article out of the way that will impede progress in the cleaning and waxing operations. The freer and clearer the area, the faster and more efficiently the work will be done. The waxing trainee should be taught carefully and gently to remove every possible obstruction.

65. Here the instructor will have a good opportunity to stress the object of adequate clearance of the work area. Removing the draperies from the work area is only one procedure in safeguarding equipment during the mopping and waxing operations.

The advantages of *prevention* over *cure* should be strongly stressed, for all too often there is no possible cure for the splashing damage which might occur during the various waxing operations.

Like the draperies, all hanging objects should be cleared out of the way so that they will not get splashed by cleaning solutions during the mopping procedures or by splashing during the waxing procedures. Neither should these objects have to suffer a "bumping" and its resultant damage during the waxing.

Prevention rather than cure will pay good dividends.

66. "Clean-up" operations can be very exasperating and very time-consuming. They are often responsible for many lost hours which might better be used in greater work coverage and in resultant higher housekeeping standards.

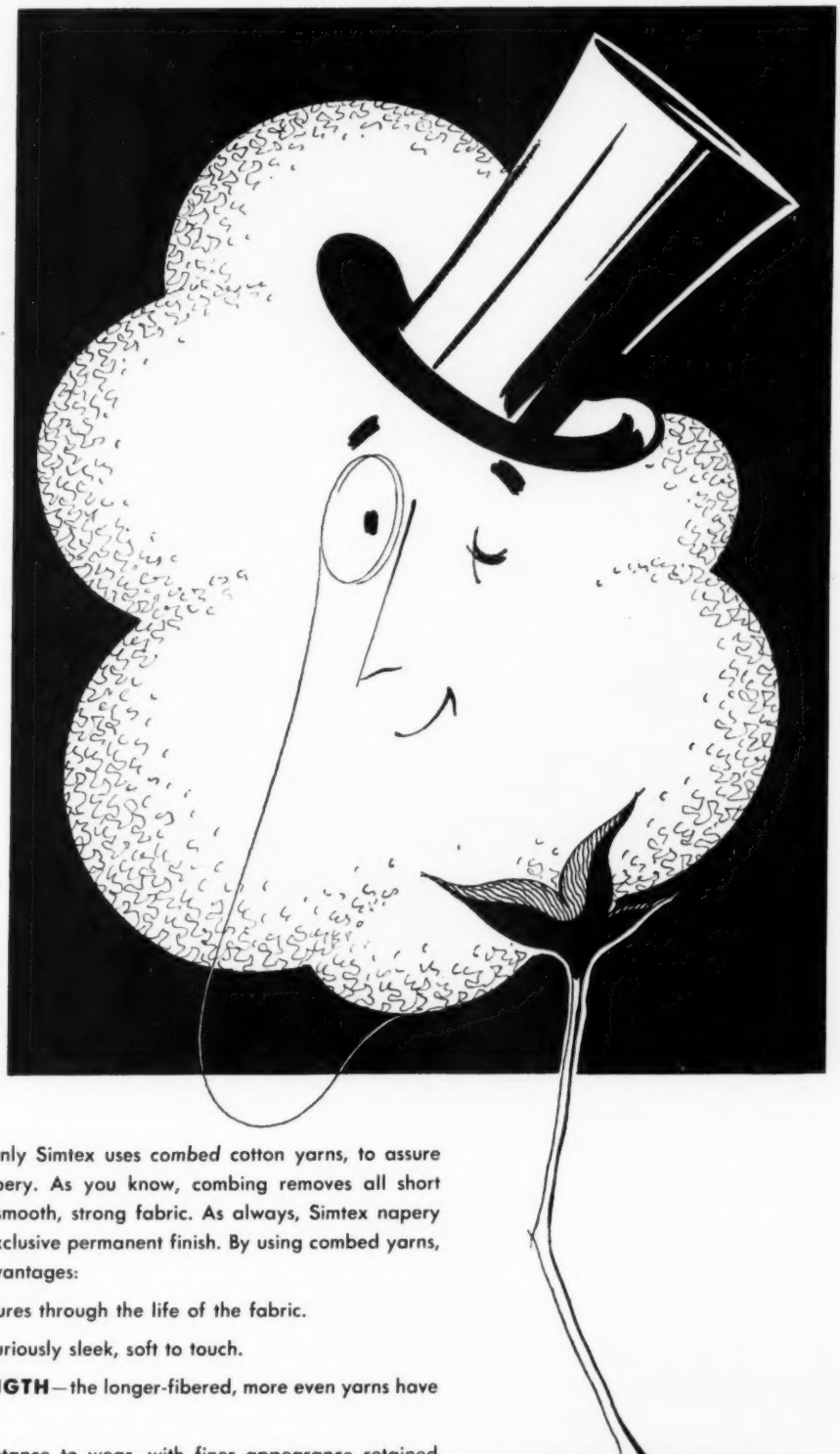
As Waxey is here demonstrating, when working up close to such surfaces as baseboards or furniture use hand methods rather than other methods which might cause splashing on unwaxed surfaces. Splashed washing solutions and/or splashed waxes are very hard to remove from such surfaces.

67. If there is a floor team, this would be the teamwork way of starting the clean-up work, prior to the final waxing operations. The teamwork plan, however, is applicable only to large hospital housekeeping.

presenting

COMBED COTTON

—tops for quality napery



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4. LONGER LIFE—stronger resistance to wear, with finer appearance retained through countless launderings.

5. GREATER ECONOMY—fewer replacements needed.

All these improvements at no increase in price

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68. So, for the purpose of this illustration and the ones immediately following, let us assume that Waxey will operate as a *one man squad* and perform all of the floor care operations by himself.

Please note that Waxey is getting off to a good start by having available the first three pieces of equipment he will need to begin the preparatory waxing operations.

69. This is Step 1 of the waxing operation: to have the floor clean of litter and soil.

70. During this damp-mopping operation, Waxey will observe the floor to see if he can possibly get by with just this simple preliminary cleaning before adding another coat of wax. Chances are that this will not be enough; he will probably have to give it the works after all.

71. If Waxey already knows the flooring, and if he is familiar with the care this floor has had, he will rarely have to make such drastic tests. However, if this is a new area to him, he will cautiously test or minutely observe the condition of the wax film that is now on the floor. Unless he can determine the condition of the flooring, and of the wax film on it, he cannot possibly proceed with his waxing assignment.

72. If there is layer upon layer of old wax film on the floor Waxey will soon realize that he has a major stripping job ahead of him before he dares apply any more coats of wax. It would be folly to build up the present film any thicker for he could never hope to attain the new sleek look that is the mark of a waxing artist.

On the other hand, he sometimes finds it necessary to check for color. Often, people wonder why the waxed floors have such a "sallow" appearance. The floors get a glazed muddy appearance even though they may not be overcoated with wax film. This sallowness is caused by deterioration and dehydration of the wax, for in aging it deteriorates into an ugly dark tan shade. This dark tan filmed coating over a flooring obscures the color in the floor and instead of being a pretty light gray, for example, it will appear a hazy dirty tan. Its appearance is so bad that it makes the whole place appear poorly maintained.

So, even if the wax film is not too old and not too thick, it will just have to come off anyway.

73. It is very possible that this wax film is neither unnecessarily thick nor even discolored with age; it just might be in a very dirty part of the hospital. If it is in a dirty area, such as the entrance or in front of elevators, or in other areas where there is an abundance of foot traffic, it may have absorbed a great deal of imbedded grime. It is harmful to the flooring to have this imbedded, sharp grime pressing through the wax coating and thus injuring the basic flooring. So this too has to come off in a hurry and be completely redone.

74. After making these tests Waxey sighs and realizes that he cannot effect any short cuts; he must strip off all old wax coats and start to apply new films of wax.

75. Waxey proceeds to strip the floor.

76. It isn't everybody who knows enough about floors to understand just how to go about stripping off old, stubborn, deteriorated films of wax. Waxey is particularly skilled at this, so let us observe how he does it.

77. Please note that Waxey's first consideration is: "How much water is it safe to put on the floor?" It will take a long time for the cleaning solution to soften or penetrate the wax film, so Waxey is safe in putting on a goodly amount of water as long as it cannot seep into crevices or under the floor tiles. He will need quite a bit of watery solution to reemulsify the stubborn old dehydrated wax coating before he can strip it off the floor.

78. Waxes vary in their consistency and in their solubility. Some will go into solution almost immediately and some may require many minutes (up to an hour) to soften and emulsify.

Before trying to instruct the waxing trainee in the use of the wax, the instructor herself should thoroughly understand just how much time the waxer will have to allow for the emulsifying solution to remain on the floor before the actual stripping can be accomplished. This can be learned in one of two ways: (1) from the source of procurement, (2) by personal testing. The test method is a simple one, and can be best done on a piece of black glass. Place the black glass flat and apply a thin, even coat of wax on it. Allow this coating of wax ample time to dry. Recoat the test spot with another thin film of wax. Allow this to dry for at least 24 hours. Next, place a few drops of water on the wax test spot. Observe the emulsifying action and time it. This will give you the length of time required to bring the wax film back into a soluble state so that it can be stripped off more easily.

It may appear difficult (and often seemingly impossible) to

bring the old, dehydrated, wax film back into a removable liquid state.

Easier removal of it may dictate the need for either a more potent cleaning solution or friction applied in order to facilitate the stripping operation. In Step 1, *i.e.* using a potent cleaning solution, it may be necessary to add a more highly alkaline material, in increased amounts, to the cleaning solution.

In Step 2 — using friction — one or both of these actions may be necessary: (a) the use of the rotary machine with either a steel wool attachment or a very stiff brush, (b) an abrasive (scouring powder) cleaning material.

Either of these two stripping steps will make strong demands upon the rinsing time that will be required, for it would be disastrous to permit a strong alkaline or an abrasive cleaner to remain on the floor for any length of time. This would precipitate early obsolescence of the flooring materials.

Old, stubborn waxes are very slow to go back into a removable solution and considerable time must be allowed for a stripping operation.

79. Here Waxey is shown using the rotary machine to provide friction in the stripping operation. Please note that in using considerable amounts of cleaning solution (which gets very mucky) to soften and emulsify old wax coatings, Waxey, in anticipation of the damage which might ensue, uses a protective device to protect adjacent property.

This protective device is termed a *template*, or (for ease of description) just a *splash board*. This splash board (or template) can easily be made of any material that will stand up alone. It can be made of heavy cardboard and disposed of when it gets too buckled or soiled for further use. It might also be made of lightweight metal which can more easily be kept clean. It should be of a size that will cover and protect a considerable span of wall area and tall enough to protect the wall or furniture from the highest splash of the circulating solution.

The waxer should have at least one pair of these splash boards, or more if the area being stripped is a large one where he will be moving along at a fairly rapid rate of speed.

80. If Waxey does not have a rotary machine to help strip off the old wax, he improvises and uses the available tools.

Though it requires more effort, a wet mop can provide considerable friction and agitation, which will help to loosen the stubborn wax film. Where the film is particularly stubborn, he also uses his deck brush to provide more friction and agitation.

Though he has not yet reached the corner he is headed that way with his mop. Please note that he has protected the corner wall surface by placing two closely butting splash boards up against the wall. He is able to swing the mop more freely when he has this protection.

81. He is careful to keep enough fluid on the floor film to hold it in solution once he has got it to that stage.

82. Unless the waxy muck accumulation is removed from the floor quickly, the moisture evaporates and the waxy muck dries. When this happens the solution settles back into the floor pores and again solidifies. This necessitates starting all over again to get the film into emulsion so that it can be removed from the floor. If the waxer trainee understands that this delay adds to his work load, he will make an effort to keep it in workable solution and avoid this extra work.

83. Once the old wax film is emulsified it must be quickly removed from the floor; the quicker the better! The most efficient piece of equipment for this quick pickup is the suction machine. It picks up muck and dirt all in a matter of minutes. It works so fast that it does not allow time for evaporation or air drying.

84. A salient reason for using the suction pickup machine is its thoroughness in removing *all of the muck* in one operation. It is very different from the mop in this respect, for the mop can remove all of this muck only through many repeated operations. The suction machine gathers it up all in one swoop. It removes it before it has an opportunity to settle back into the floor pores.

Because it does such a complete job of removing slushy muck it reduces the need for so many rinsing operations. Where three or four rinsing operations are required with the mop-removal method, usually only two rinsings will be needed after a suction machine has been used.

85. This method is much slower than the suction machine but it can be equally effective if done properly.

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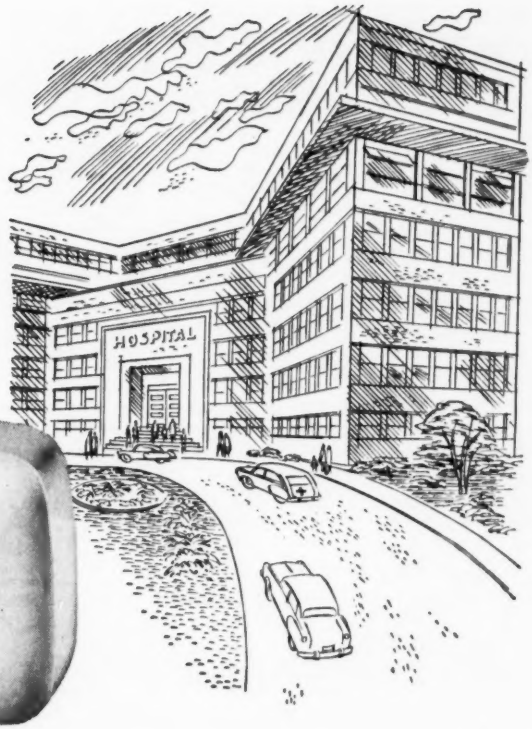

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The water pan is constructed to hold and trap about a gallon of fluid. It requires frequent emptying. Any of the styles of squeegee which are shown in either this manual or the Moppy manual will work well with this pickup pan.

With the rubber edge of the squeegee pressed firmly against the floor, just push the mucky solution over the lip and into the pickup pan. If this is done with the squeegee blade pressed firmly against the floor, a very thorough and clean operation will result. This method can be used for both the mucky pickup and for the later pickup of the rinsing waters.

86. The floor must be thoroughly clean and thoroughly dry before Waxey begins his next waxing operation. He carries his cleanliness pattern to its full extent by cleaning the equipment he has just used. He finds that he has time for this while he is waiting for the floor to get dry enough to wax.
87. Like any good housekeeper, Waxey uses the few minutes during which the floor is drying to clean the articles he has just finished using, so that they will be in readiness the next time he needs them. He gets a lot of satisfaction out of always having clean tools to work with.
88. In order to produce a quality job of wax application, it is imperative that the wax applicator be immaculately clean and soft enough to produce a smooth, even film upon the floor. A harsh or dirty applicator will produce an uneven or a "bloomed" wax film, which can never be obliterated by the later buffing operations.
89. If there is an accumulation of an old soap solution within the wax-applicator fibers, the old soap will merge with the new wax and throw it chemically off balance. If there is much of it, it will serve to counter the antislip quality of the wax—and you will wonder why the wax has suddenly become slippery.

    This soapy content will also leave a "bloom" on the floor, which will not be obliterated by the later buffing operations. This "bloom" is what is usually responsible for that hazy streaked appearance.
90. If the wax-filled applicator is allowed to dry with the imbedded wax in its fibers, the solidified wax will become too hard to remove. It will take innumerable washings to get the applicator into acceptable, clean and smooth condition. It will be hard to avoid making streaky applications with it.

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Send me FREE, colorful literature that will tell me how to lower maintenance costs, improve each cleaning job. Also tell me about Clarke Floor Maintainers.

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PROTOTYPE STUDY: 25 BED HOSPITAL

(Continued From Page 56)

from nonhospital sources, and 69 per cent from Red Cross centers.

Dietary. Approximately 30,000 meals are served annually; 15,000 to patients and 15,000 to employes and others.

Only 1 hospital in 33 employs a qualified dietitian. Those that do average one such person per hospital.

Better than 9 in 10 hospitals have a centralized food service.

Almost 1 hospital in 4 has selective menus for all patients; 1 in 20 has it for private patients only. Almost three-fourths of the hospitals do not offer selective menus.

Almost one hospital in 2 has manual and centralized dishwashing service. An equal number have mechanical and centralized dishwashing service.

Three hospitals in 4 use gas for cooking.

Laundry. Approximately 49 per cent of the hospitals operate their own laundry. Those that do operate a laundry average 1 employe for every 12 to 13 hospital beds. In these hospitals the laundry processes between 55,000 and 65,000 pounds, or 110,000 to 130,000 pieces per year.

Ambulance. Four in 5 hospitals report the provision of ambulance service; 3 in 50 own and operate their own ambulances, 1 in 10 uses city or publicly owned ambulances, and 4 in 5 use private nonhospital ambulances.

FINANCIAL

Assets. Total assets per bed amount to approximately $7000.

Plant assets amount to about $5000, or 71 per cent of total assets.

Replacement Funds. Three hospitals in 10 indicate a need for replacement funds for obsolete equipment and service departments of hospital plants including replacement or expansion of service facilities and replacement but not expansion of bed complement.

This need amounts to between $90,000 and $100,000 per hospital.

Expenses. Expenses approximate $88,000 to $96,000 per year.

Average expense per patient day amounted to $16.

Average expense per patient stay amounted to $96.

Pay Roll. Average annual pay roll amounted to $46,750 to $51,000.

Average annual salary per employe approximated $1950.

Average pay roll amounted to $8.50 per patient day.

Average starting salary per month amounted to $225 for general duty nurses, $124 for untrained women, $151 for untrained men, $154 for clerks, and $160 for practical nurses.

Departmental Expense. The departmental breakdown of expense shows:

Administration and business office	8- 9 per cent
Dietary	18-19 per cent
Laundry	5- 6 per cent
Housekeeping	4- 5 per cent
Plant operation	8- 9 per cent
Medical and surgical	11-12 per cent
Nursing	34-35 per cent
X-ray	5- 6 per cent
Laboratory	2- 3 per cent
Other	1- 2 per cent

Income. Patient income for the year approximated $85,000 to $93,000.

Patient income per patient day averaged $15.50.

Average patient income per patient stay amounted to $93.

Patient income amounted to about 96 to 97 per cent of total expenses.

BLUE CROSS WILL ENDURE—IF

(*Continued From Page 66*)

laboring the shortcomings of either of these methods, I submit that we must make up our minds. We must determine the proper place and the most effective sphere of activity of each of these enrollment procedures, and make that decision a matter of national policy. Although there may be questions concerning the details involved, there should be no question as to the purpose we must serve. Our task is to provide benefits that meet the needs and demands of our membership. The method of payment and other mechanics of national enrollment are secondary in importance. We can do the national enrollment job that needs to be done only if we present a united front. We must have a definite program—one that inspires confidence—and faith in our vision and ability to overcome the obstacles that lie ahead in the field of health care.

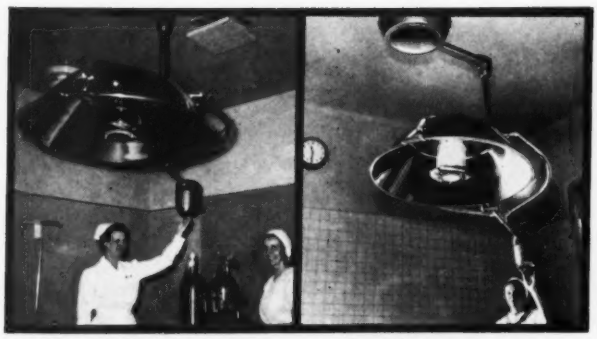
In meeting local situations, too, we have ventured forth in many directions. Some plans have experimented with control factors, such as deductible clauses, indemnities, co-insurance, to check utilization and hold subscription rates down. We have also considered the possibility of providing diagnostic coverage, benefits for nervous and mental disorders, tuberculosis and home nursing care, and other innovations that might make our protection more effective and attractive. Some of these ventures will, in the long run, become valuable features of the prepayment program. Others may not.

A PATTERN IS LACKING

The point here is that there has been no pattern for the development of these experiments. We lack a method of measuring our individual decisions against our national objective. There has been no constant guide for the deliberations that are carried on continuously in the administrative offices and board rooms of all our plans in the search for answers to the pressing problems of our times. In too many cases, we act independently of each other, and there is some danger that in this way we are growing away from each other—away from basic Blue Cross and Blue Shield objectives. In our efforts to gain enrollment and maintain the stability of each component part, we may be overlooking the growth and balance of our program as a whole.

It is difficult to define the point at which a strength becomes a weakness. Our greatest asset has been, and always will be, the autonomous structure of each plan. We are strong individually because we have intimate knowledge of our community needs. We are in a position to be strong nationally only because we are strong locally. However, I believe we have reached the point where some of the factors which contributed to the strength of Blue Cross and Blue Shield may now detract from it. Just as surely as lack of coordination in the formative years of the voluntary hospital system led to a haphazard and costly development in most areas, lack of coordination in our own program can destroy the hope for efficient, economical growth. Independent action and initiative are vital to

(*Continued on Page 138*)



SALEM, OREGON—'The Surg-o-beam light maneuvers wonderfully and there is now no need for auxiliary lighting," observes Miss L.M. McDonald, left, Superintendent, Salem General Hospital.

NEW YORK CITY—'The Surg-o-beam is especially easy to maneuver and adjust," says Mrs. E. Davis, Circulating Nurse of Manhattan General Hospital.

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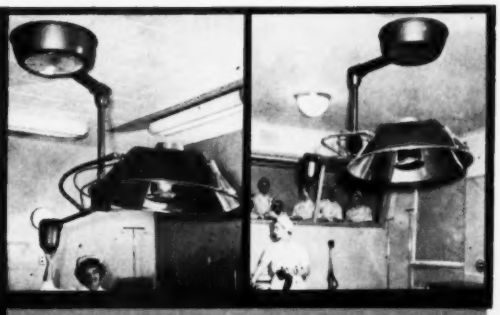
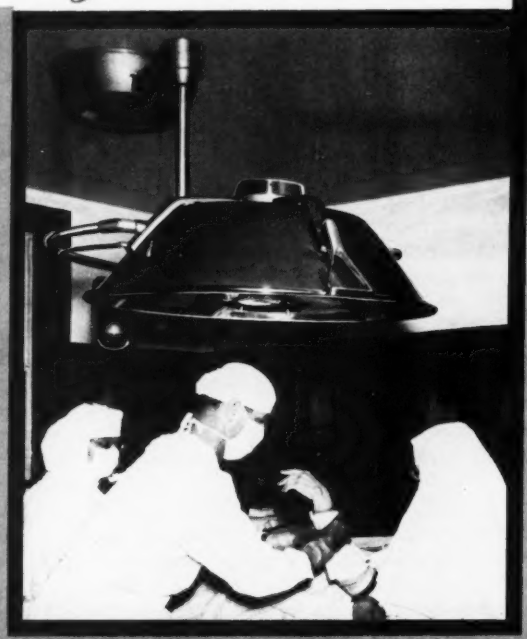


NEW BRAUNFELS, TEXAS — "Coolness of the light, ease of positioning, and fine appearance are outstanding Surg-o-beam features," says Mr. George Berryman, Hospital Administrator.

MONTREAL, CANADA — Student nurses Denise Le Francois and Jacqueline Hebert inspect Ohio Chemical equipment in one of the 16 operating rooms at Hotel Dieu.

OHIO'S NEW *Surg·o·beam*



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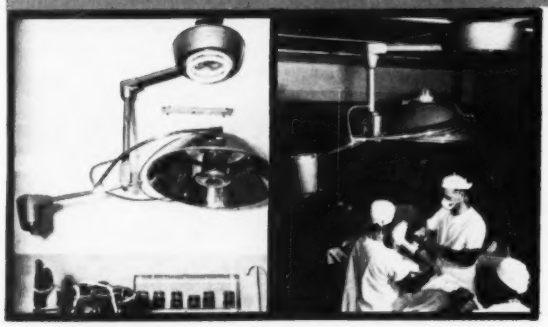

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any voluntary enterprise. But when such an enterprise is made up of many units, separated by geographic boundaries and varying social and financial conditions, some over-all pattern of development also is essential. We are making decisions and exploring new approaches to the problem of health care to the best of our individual ability and, probably, in the best interests of our plans and our communities. But do we often enough relate our thoughts and actions to the national situation and our greater objective?

We obtain and exchange information and ideas through our respective commissions. Various committees are at work studying problems common to all of us. We have an opportunity to share experiences and plans in conferences. Our approval standards also help to maintain our identity. I do not underestimate the value of what is being done. Our record of accomplishment as a voluntary, cooperative program is almost without equal in world history. Each of us should find it a source of pride, satisfaction and inspiration. But I do suggest that we reexamine our present structure to find channels for the leadership necessary to assure our continued progress along a straight line toward a clearly defined goal.

We have told ourselves and the public for many years that we can meet the health needs of the nation on a voluntary prepayment basis. Now we are being told that we must meet those needs or leave the solution to some other type of program. And it is strongly indicated that we must think in terms of tomorrow's needs, not those of yesterday.

In many respects, the decision as to the amount and the nature of the services we will make available has been taken out of our hands. Tomorrow's need has been stated, by the labor unions and leaders in management, to be one of full coverage on a service benefit basis. Full protection, including the prevention and diagnosis as well as the treatment of disease, has been established as the goal. Powerful forces are driving toward that goal. Why should we resist them? They are doing no more than driving us toward our own objective.

We have the initiative as of this moment. Despite the fact that one great industry has set up its own program and is building its own hospitals, labor and industry in general look to us for the answer. Despite the fact that there are other promising voluntary programs in existence, the public looks to us for the solution. And we can be sure that partial answers, or half-way solutions, will not be accepted for any length of time.

The attitude toward health care has changed considerably in this country during recent years. Hospital and medical attention is regarded today as a necessity for all rather than a privilege for some. If the voluntary prepayment program fails to recognize that attitude, then health care may well become another function of government. The public is no longer a passive witness; the public is an active participant in our affairs.

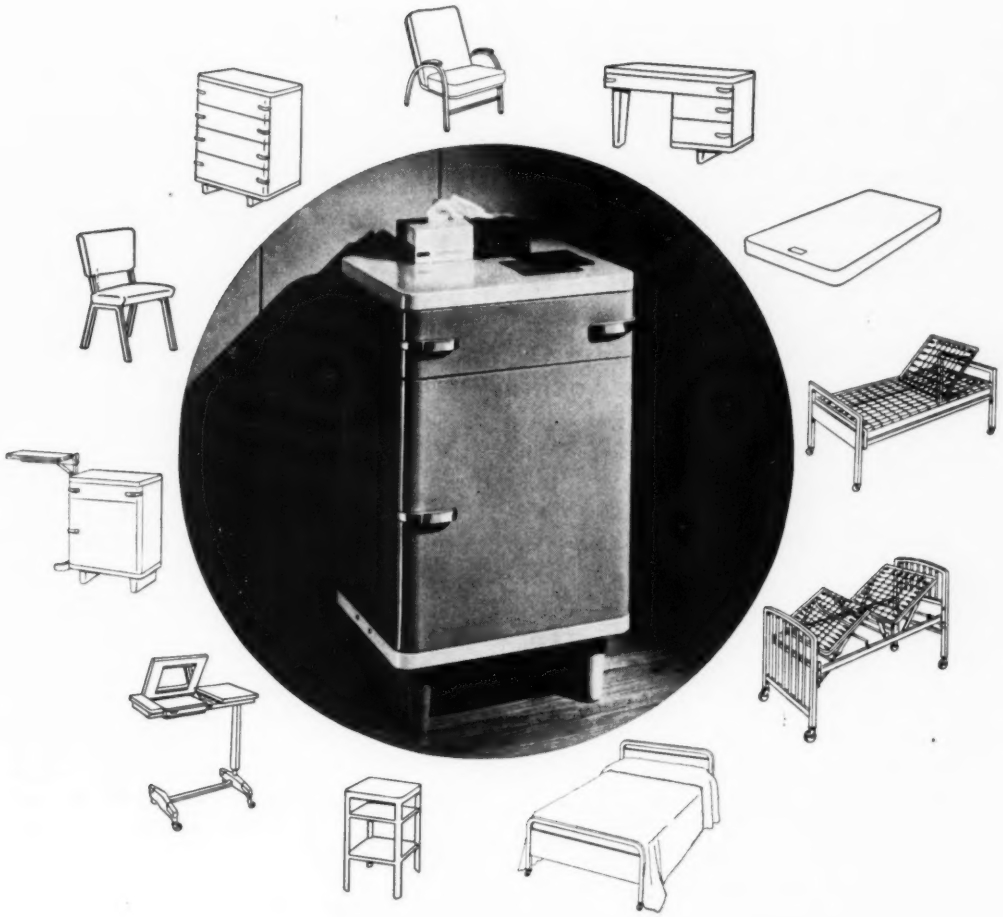
HAVE NATIONAL IMPLICATIONS

As a result, many of the issues with which we deal on a local basis today have far-reaching national implications. We are 86 Blue Cross plans and 78 Blue Shield plans, but in the public estimate, we are one health care program. Regardless of what we do, or fail to do, we help or injure that program. We must accept that fact, and accept the need for more unified action and more unified leadership in every major issue.

The importance of coordinated thinking on such issues has been recognized and stressed by many in the Blue Cross movement throughout the years. We have nodded our heads in happy agreement, but have done little to transform preaching into practice. If we continue to stand still on that point, we may soon find that we are no longer standing on common ground.

We have an opportunity for positive action. Let us lift our eyes to the good that has been done and the great good that remains to be done. Instead of looking uneasily at the shadow cast by competition and trying to make our own conform to its outline, let us reaffirm our objective and join all our forces to gain it. In our generation the people have come to realize that their health is the basis not alone of individual and family happiness. The health of the people determines the health of our entire economic and political structure. It is this foundation for a sound economy which the people seek.

In reality, we have no competition, for ours is the only program dedicated to meet the health needs of the community and the nation. It is the only program so designed that it can be dedicated to that purpose. We, alone, have that objective. We, together, can achieve it.



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NEWS DIGEST

Florida Meeting Features "Grin and Bear It" Session . . . Blue Shield Plans Uphold Medical Indemnity, Inc. . . . Protestant Groups Announce Programs . . . Consultation Standard Set . . . Hospitals Merge . . . Pittsburgh Gets $15,000,000

Florida Association Hears Candid Opinions of Hospitals; Forms Women's Auxiliary

MIAMI BEACH, FLA.—With a record attendance of more than 360, the Florida Hospital Association held its annual meeting here early in December. Meeting in concurrent sessions were the following groups: Florida Blue Cross, women's auxiliaries, hospital pharmacists, and the medical record librarians.

High points of the meetings were: (1) "a candid opinion of hospitals" session, presided over by Everett W. Jones of Chicago, in which a representative from the press, the public, the medical profession, the nurses, and the trustees told what they liked and disliked about hospitals, and (2) the organization of the Women's Auxiliary of Florida Hospitals, with Mrs. Tracy B. Hare of Miami as its first president.

The "Grin and Bear It" session solicited specific criticism of hospital service and practices from both the groups represented and the public. After the invited speakers had their say, they automatically became members of a panel and handled hot questions from the audience. There ensued a full hour of give-and-take between the audience and members of the panel.

New officers of the association are: to succeed T. F. Little as president, John Wymer Jr., administrator, Good Samaritan Hospital, West Palm Beach; president-elect, Pat Groner, administrator of Baptist Hospital, Pensacola; secretary-treasurer, Mary J. Reeder, administrator of Doctors' Hospital, Coral Gables; trustees, T. F. Little of Halifax District Hospital, Daytona Beach, and Ben P. Wilson, administrator of Munroe Memorial Hospital, Ocala; delegate to the A.H.A., Norman Losh, administrator of Orange Memorial Hospital, Orlando; alternate delegate, Tracy B. Hare, administrator of Variety Children's Hospital, Miami.

Out-of-state speakers included Howard Cook of the A.H.A., Leo Brown of the A.M.A., and Dr. Louis Block of the U.S. Public Health Service.

Florida's new officers, l. to r.: John Wymer Jr., president; Mary J. Reeder, secretary-treasurer; Pat Groner, president-elect.

Preston B. Bird, chairman of the Dade County Board of Commissioners' committee on homes, hospitals and welfare, told the convention that hospitals in Florida have kept pace with population growth and have contributed greatly to the health, and therefore to the progress, of the state. "Hospitals must intensify their efforts to give the public all the facts on hospital operation and costs, if they expect to improve their relations with the general public," declared Mr. Bird.

Herman Hoff, director of personnel at Jackson Memorial Hospital, Miami, reported on a thorough study being made by the personnel committee of the state association in every section of Florida. Efforts are being made to keep complete data on the wages, working conditions, and permanent recruiting programs of all hospitals of the state at the central state association headquarters offices, so that this information may be available for any hospital wanting it.

Sam Gertner, administrator of Mount Sinai Hospital, Miami Beach, reporting for the insurance committee, stressed the necessity for safety programs and careful investigation of all

(*Continued on Page* 196)

Blue Shield Plans Reject Proposal to Limit Scope of Medical Indemnity, Inc.

CHICAGO.—A proposal to prohibit Medical Indemnity of America, Inc., the national insurance company operated by the Blue Shield Commission, from writing national contracts that would prevent any local group from obtaining local Blue Shield benefits was defeated overwhelmingly by representatives of Blue Shield plans at a special meeting here January 17. The resolution was introduced by Dr. Charles Gordon Heyd of New York, past president of the American Medical Association, and was endorsed by representatives of Blue Shield plans from Illinois, Pennsylvania, Connecticut, Massachusetts, New Jersey, and Wyoming.

DEFEATED BY 4 TO 1 VOTE

The resolution was defeated by a four to one vote. Opponents of the proposal, which also provided that Medical Indemnity, Inc., should not write any national contracts providing "coverage less than the fee schedule of any local plan in whose area a substantial number of employes are located," and that the Blue Shield name and symbol should not be used in connection with any contract "providing coverage for professional medical services within the area of any Blue Shield plan except with the prior written consent in each instance of such local Blue Shield plan," maintained that these restrictions would so limit the operations of Medical Indemnity of America, Inc., as to leave it without any practical, national underwriting function to perform.

The meeting, which was attended by more than 200 Blue Shield representatives, was called to consider what action should be taken following approval by the A.M.A. House of Delegates last December of a resolution

(*Continued on Page* 142)

condemning Health Service, Inc., the Blue Cross insurance company affiliated with Medical Indemnity of America, Inc., for writing a national contract including medical services as "hospital benefits." After rejecting the resolution introduced by Dr. Heyd and discussing a number of similar resolutions and policy statements, the representatives referred the resolutions and statements on inclusion of medical services in prepayment plans to the Blue Shield Commission for study.

Protestant Hospital Groups Outline Convention Programs; Nuveen Is Banquet Speaker

CHICAGO.—Preceded by two days of denominational meetings, the American Protestant Hospital Association will convene in the Palmer House here on February 11 and 12.

On the afternoon of February 11 and the morning of the Great Emancipator's birthday the Association of Protestant Hospital Chaplains will also meet. There will be a joint banquet on the opening night, the speaker being John Nuveen, president of the Chicago Sunday Evening Club and partner in the investment banking firm of John Nuveen and Company.

Friday's sessions of the A.P.H.A. feature the Rev. Thomas K. Thompson of the department of stewardship, National Council of Churches of Christ in the U.S.A., in a talk on "Christian Methods in Raising Capital Funds," and a paper by Julia Defenderfer, administrative supervisor in medical nursing, Massachusetts General Hospital, Boston, on "Spiritual Factors in Nursing Care." Mrs. Defenderfer is the wife of Chaplain R. C. Defenderfer of Metropolitan State Hospital, Waltham, Mass.

On Friday morning also there will be a panel discussion on "A Christian Atmosphere in the Church Related Hospital—How to Get It." Taking part as discussion leaders are: Alfred D. Biggs, member of the medical staff of St. Luke's Hospital, Chicago; Sister Hilda Muensterman, director of nurses, Evangelical Deaconess Hospital, St. Louis; Frank Tripp, D.D., administrator of Southern Baptist Hospital, New Orleans, and Rev. Lester W. Draheim, chaplain of Lutheran Hospital, Cleveland. The last two speakers will discuss employe relations and patient relations, respectively.

Lee S. Lanpher, head of Lutheran Hospital, Cleveland, is president of the A.P.H.A.; C. E. Copeland of Missouri Baptist Hospital, St. Louis, will take over the presidency at the close of the meetings. Lloyd E. Beebe of the Federation of Churches, Albany, N.Y., is president of the chaplains' association.

The main speakers at the chaplains' meeting will be Dr. Andrew Elia of Massachusetts Memorial Hospital, Boston, and Dr. S. W. Richardson, chaplain of Booth Memorial Hospital, Covington, Ky.

The National Association of Methodist Hospitals and Homes is calling its annual convention on February 10 and 11 "Christianity in Action." Its banquet speaker is Dr. Leonard A. Scheele, surgeon general of the U.S. Public Health Service. Four Wednesday afternoon and Thursday section meetings are scheduled. These include the following sections of the associa-

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tion: hospitals, homes for the aged, homes for children, homes for youth and deaconesses, chaplains, women's auxiliaries, and conference chairmen.

President Harold Prather and his officers have arranged a diversified program for the Southwide Baptist Hospital Association for Wednesday afternoon and Thursday. The report of the committee on a full-time executive secretary will be heard and discussed, and there will be a buzz session along with a number of speeches.

At the Episcopal Hospital Assembly, the Rt. Rev. Harold L. Bowen, bishop of Colorado, will be the banquet speaker.

Theme of the sessions of the Commission on Benevolent Institutions of the Evangelical and Reformed Church is "Unique Contributions of Our Church Related Institutions." This, too, will be the subject of a paper on February 10 by John Park Lee, director of the division of welfare agencies, Presbyterian Church of the U.S.A.

Attorney Louis Goebel is to speak on "Wills, Estates, Foundations and Annuities" on February 11, and resource leaders will add to the topic and answer questions.

The Association of Mennonite Hospitals and Homes begins its meetings with a fellowship dinner on Wednesday evening, February 10, after which H. J. Andres, administrator of Bethel Deaconess Home and Hospital, Newton, Kan., will lead a group discussion on "Our Major Concerns in Patient Care." The next day Dr. Edward P. Mininger of Elkhart, Ind., will lecture and lead a discussion on "Integrating Professional Services in a Christian Institution."

Chicago and Wesley Memorial Hospitals Announce Merger Plans

CHICAGO. — Effective July 1, Wesley Memorial Hospital and Chicago Memorial Hospital will merge their facilities, it was announced here last month by Vernon R. Loucks, president of the board of Chicago Memorial, and James F. Stiles Jr., president of the board of Wesley Memorial.

Plans for a new five-story addition to Wesley were made known at the same time.

The combined institutions will be known as Chicago Wesley Memorial Hospital. After the unification, the 100 beds of Chicago Memorial Hospital will be taken over for convalescent care.

Three main objectives to be gained by the unification were outlined in the announcement.

First, more and better service to be provided for patients as a result of the enlarged medical staff and additional physical facilities, including the new building, with a capacity of 117 beds, in addition to Wesley's present capacity of 617 beds.

Second, in cooperation with the medical school of Northwestern University, educational opportunities will be expanded for medical students, students in the various adjuncts of medicine, and the medical and nursing professions.

Third, medical knowledge will be advanced through more extended study and research in cooperation with the Northwestern University Medical School.

All These Famous Heinz Ready-To-Serve Varieties Now In 49-oz. Chef-Size Tins!

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NEWS . . .

Accreditation Commission Seeks Suggestions on Consultation Standard

CHICAGO.—Hospitals were invited to make comments or suggestions on the new consultation standard approved last month by the Joint Commission on Accreditation of Hospitals, according to a bulletin released here by Dr. Edwin L. Crosby, director of the Commission.

Following release of the new standard, the Commission asked its committee on consultation to continue its study and report again after July 1, 1954, the bulletin said. "The committee would appreciate comments or suggestions from any interested individual or group," Dr. Crosby stated.

As approved by the Commission, the new standard now provides:

"Except in emergency, consultation with a member of the consulting or of the active medical staff shall be required in all major cases in which the patient is not a good risk, or in which the diagnosis is obscure, and in all first cesarean sections, sterilizations, curettages or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation, the consultant may, and in the case of free patients shall, give his services without charge. This standard is applicable to all members of the medical staff."

The bulletin also reported a joint meeting of representatives of the Commission and members of the committee on hospitals of the American Academy of General Practice. After discussion, the group agreed on the following standard, the bulletin reported:

"In a well departmentalized hospital electing to hold at least monthly clinical departmental meetings and quarterly general medical staff meetings, a doctor who holds an 'active staff' appointment in a department of general practice should attend at least nine (75 per cent of 12) departmental meetings per year held by the clinical services in which he has privileges, in addition to 75 per cent attendance at the quarterly meetings of the entire active medical staff. One of the two following patterns for attendance at clinical departmental meetings should be followed by "an active staff mem-

be followed by an 'active staff member' of a department of general practice:

"1. If he has privileges as an 'active staff member' in a clinical department, he should attend 75 per cent of the monthly meetings of that department just as all other active staff members of that clinical department do. It is understood that no physician will have 'active staff' appointment in more than one clinical department, or

"2. If he has privileges other than as an 'active staff member' in clinical departments, he should attend at least nine departmental meetings per year among the clinical services in which he has such privileges. The clinical departmental meetings attended shall be of his own choice, with the exception that he might be requested to attend a particular departmental clinical meeting."

Reporting on surveys conducted by the Commission during the first eleven months of 1953, the bulletin said the field staffs had observed the following factors affecting patient care as major deficiencies noted during the surveys:

"1. Fire hazards.

"2. Need for improvement in the active supervision of the clinical work done in the hospital by a well organized medical staff which is self-governing, subject to the ultimate authority of the governing body of the hospital.

"3. Need for improvement in the thorough review, analysis and evaluation of the clinical work done in the hospital on at least a monthly basis throughout the year.

"4. Insufficiently recorded essential clinical entries on the medical records to establish the diagnosis and support the treatment.

"5. Excessively high and unexplained rates for morbidity, cesarean sections, 'not justified' removal of 'normal tissue' and infant, maternal, anesthetic and total mortality in a hospital."

Heads Hospital Accountants Association

Sister M. Gerald

ROCHESTER, N.Y.—Sister M. Gerald, general treasurer of the Sisters of the Holy Cross, Notre Dame, Ind., has been elected president of the American Association of Hospital Accountants, it was announced here by F. C. Morgan, association secretary-treasurer, last month.

Founded in 1906, the association has 1800 members in the United States and Canada as well as in several foreign countries.

Roy Heads Memphis Group

MEMPHIS, TENN.—Ralph L. Roy, administrator of Memphis Eye, Ear, Nose and Throat Hospital, became president of the Memphis Hospital Association at its annual banquet at Peabody College here last month.

Mr. Roy succeeded S. Truman Lewis, executive secretary of the Hospital for Crippled Adults. Freemen E. May, administrator of Le Bonheur Children's Hospital, was elected secretary-treasurer.

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Like fine surgical instruments . . . the right Crane equipment in the right places can increase the efficiency and save precious time of doctors, nurses, orderlies, and aids. That's why ample and proper location of water supply and waste lines is so vital in good hospital planning.

Crane offers a large selection of specialized hospital fixtures for every plumbing need. Designed with the help of hospital experts, they can speed countless time-consuming tasks.

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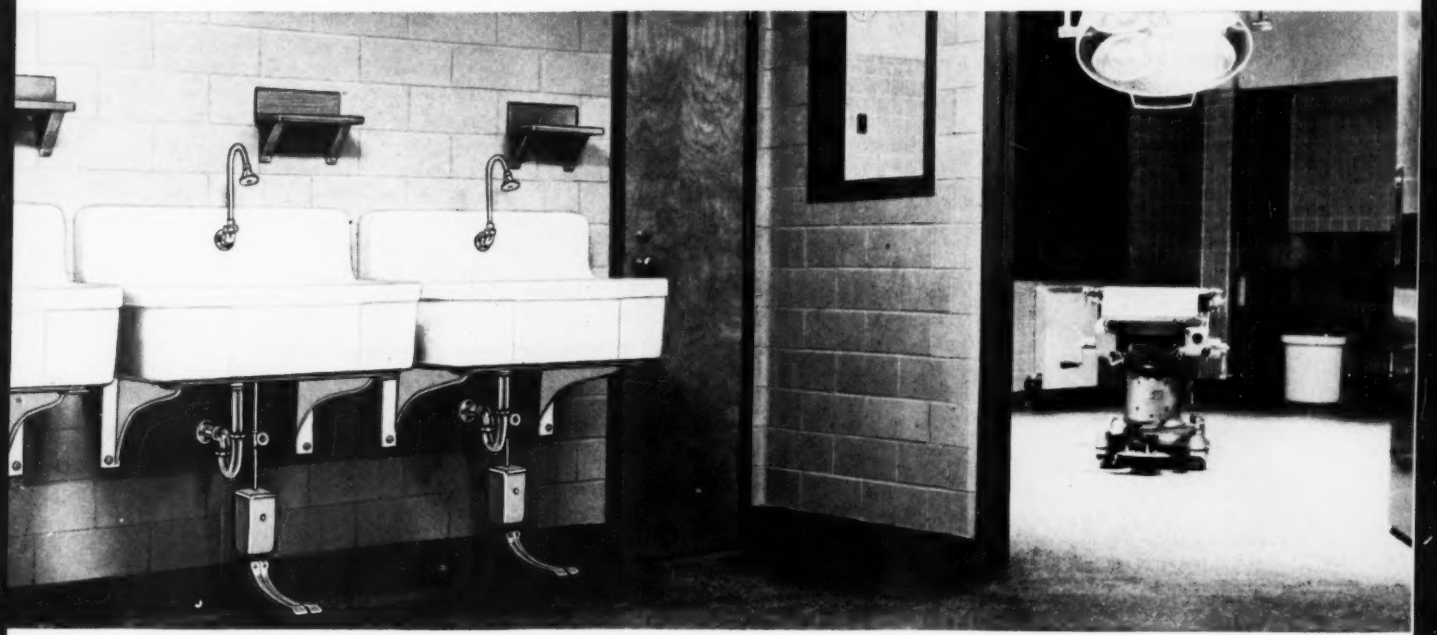

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NEWS...

$15,000,000 Given to Pittsburgh Medical School for Full-Time Faculty

PITTSBURGH. — Endowment grants totaling $15,000,000 have been made to the University of Pittsburgh Medical School, the university announced here last month. The grants were made jointly by the A. W. Mellon Trust, the Sarah Mellon Scaife Foundation, and the Richard King Mellon Foundation, it was explained. The funds will be used "to build a strong full-time faculty as a supplement to the present staff of part-time faculty members," the university announcement said.

At an announcement dinner, Dr. Robert A. Moore, vice chancellor in charge of the university's health profession schools, said the grants would make possible development of the university health center into a complete and integrated organization. "Dr. Moore advocated a full-time faculty to work in close coordination with part-time faculty members," the university announcement said. "He has indicated that the medical education program will stress the teaching of preventive medicine. His program will emphasize the training of the general physician instead of placing undue emphasis on medical specialties. He has been a strong exponent of the concept of rehabilitation, a concept which emphasizes the interrelation of both mental and physical factors."

Another speaker at the dinner, Dr. Lowell J. Reed, president of the Johns Hopkins University, emphasized the desirability of the unrestricted nature of the endowment grants. "Too frequently private gifts to universities take some specialized form and support activities that do not really strengthen the core of the university," Dr. Reed stated.

Various commissions and committees in recent years have been studying medical schools and medical education, and have called attention to the plight of the schools, Dr. Reed noted. "This plight has been presented in terms of their financial need but it should be understood that in the background there are fundamental changes taking place that produce the need for additional resources," he declared.

Changes in medical education are demanded by a constantly expanding science, Dr. Reed pointed out. In addition, he explained, "the young man

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NEWS...

entering medicine must be trained to develop that more subtle but extremely important skill that is embraced within the phrase, the art of medicine. This means that he must become adept in dealing with patients as human beings, putting into practice those aspects of medicine that go far beyond our present scientific knowledge of physiology and disease."

The Mellon gifts were described by Dr. Reed as a challenge to the university — "a challenge to develop at the highest level of quality and excellence, for in the last analysis it is not buildings and financial resources, but men of high quality, that make an institution great."

In addition to the present grants for development of the full-time faculty, an additional $15,000,000 of funds will be sought during the next five years to complete the program projected by Dr. Moore, the university said.

California Medical Center Reorganizes Administrative Setup of Two Hospitals

SAN FRANCISCO.—A new administrative organization has been effected here, it was announced last month, to operate the University of California Medical Center—which will comprise the present University of California Hospital and the Herbert C. Moffitt Teaching Hospital to be completed in December of this year.

William B. Hall, administrator of the University Hospital since 1947, will serve as administrator of both hospitals and of related activities such as the outpatient department, nurses' dormitories, and house staff quarters.

Harold Hixon, assistant hospital administrator and business manager of the San Francisco campus since 1949, has been named associate administrator and will be concerned within the immediate future with plans for opening the new teaching hospital.

George H. Vogt and Jerome M. Yalon, both assistant administrators of the University Hospital, have been appointed assistant administrators.

Stanley C. Bateman, accounting officer on the San Francisco campus for the last 18 months, becomes business manager; and William W. Robertson, a member of the controller's staff for the past year, has been appointed accounting officer.

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ACA-C-41

NEWS...

Three Nursing Homes Affiliate With Vancouver for Chronic Disease Care

BALTIMORE. — The story of the Vancouver General Hospital's direct affiliation with three nursing homes to provide a full range of facilities is told in the January newsletter of the Commission on Chronic Illness, with headquarters here.

The service, as now constituted, means more than service to Vancouver and its environs, it would appear, for the province of British Columbia also is served, inasmuch as there is a tendency for older citizens of the province to gravitate to Vancouver upon retirement. Moreover, the medical center at Vancouver attracts difficult cases which receive diagnosis and treatment in the city and, in many instances, they remain there as chronic cases.

Another point leading to the development of the affiliation is the fact that Vancouver General Hospital is operating at 98.9 per cent of capacity and its adjunct nursing homes at 100 per cent or more.

To release for the care of acute disease patients much needed beds in Vancouver General's 1500 bed hospital, the hospital first took over, for the care of indigent male patients with chronic disease, Heather Annex Hospital. Heather Annex was a section of Vancouver General itself, having been originally built for the care of influenza patients.

Although Vancouver General is a voluntary institution, its "free work" is supported by appropriations both from the city and the province. Admission to Heather Annex is handled by the city's social service department in close affiliation with the hospital's social service department.

The hospital provides medical and intern services, orderly service, dietetic service, limited laboratory services and general administration. It is included in Vancouver General's budget with reimbursement given by the municipal and provincial governments.

Similar accommodations were needed for women indigent patients, which the city's social service department had originally met by arranging for facilities in private nursing homes. Eventually this responsibility was assumed by the hospital, which paid a per diem rate for the care of patients and was reimbursed by the city, the newsletter of the Commission on Chronic Illness points out.

As the program now operates the hospital has an agreement with two nursing homes — Glen Hospital and Grandview Hospital, each 5 miles away — whereby Vancouver General patients only are admitted, the hospital paying the homes on a per diem basis. This arrangement of per diem payment dates back to 1948 and the enactment of the Hospital Insurance Program in British Columbia.

Beds in the nursing homes may not be available immediately, but the patients on the waiting list do not mind, for they are "waiting" under the care of the hospital.

When the nursing home patient's condition is classified as "emergent," the patient is transferred back to the hospital. No beds are specifically held in reserve for these patients.

Vancouver General Hospital employs a part-time physician who at-

NEWS...

tends to the medical needs of all patients in the three nursing homes.

The city of Vancouver is considering the erection of a 500 bed hospital for the sole care of convalescent and chronically ill patients. It is not anticipated that this development will affect significantly the existing nursing home affiliation since it provides primarily custodial care. The new hospital will provide special treatment facilities to help rehabilitate the chronically sick, the Commission says in its report.

Mrs. Hobby Will Speak at New England Meeting

BOSTON.—More than 4000 hospital administrators, trustees, doctors, nurses and members of hospital staffs from all parts of New England and the nation are expected to be in attendance here for the three-day conference of the New England Hospital Assembly. Its 31st annual meeting will take place March 29 to 31.

The program as announced by William L. Wilson of the Mary Hitchcock Memorial Hospital, Hanover, N.H., chairman of the assembly, will have more than 100 speakers of local and national note in the hospital field, including Oveta Culp Hobby, Secretary of Health, Education and Welfare, Washington, D.C., and Ritz E. Heerman, president of the American Hospital Association. To date, 20 sessions, dealing with every phase of hospital operation, have been planned to discuss present-day problems of hospital administrators, trustees, staff workers and volunteers. In addition to the general session, the assembly will hold its annual trustee institute with Assembly President Dr. Frederick T. Hill, director of Thayer Hospital, Waterville, Me., as chairman. The institute, begun in 1947 and now an annual feature of the assembly, is designed to help the trustees more adequately meet and solve the problems of hospital finance and hospital policy.

Manufacturers and representatives of hospital and medical equipment and supplies will occupy more than 100 booths in the Statler's ballroom and foyer during the session, according to the exhibit manager, William S. Brines, director of the Malden Hospital, Malden, Mass.

Michael Reese Starts Construction of New Unit

CHICAGO.—Ground was broken here early last month for Michael Reese Medical Center's new $3,500,000, 120 bed pavilion and professional services building.

The new building, designed by Loebl, Schlossman and Bennett, will be connected with the medical center's 16 existing structures at the ground and second floor levels.

Plans for each of the four patient floors call for eight private and 10 semiprivate rooms, and include two-way intercommunication with nursing stations, oxygen piped to each bedside, a four-way lighting system, and individualized room temperature control.

Cast rooms and an x-ray department, which will be the largest in the Midwest, will be housed on the second floor of the new pavilion.

Building foundations will provide for construction of six additional floors in the future. The present new facility, expected to reach completion in 18 months, will bring the bed capacity of the medical center to 888, it was announced.

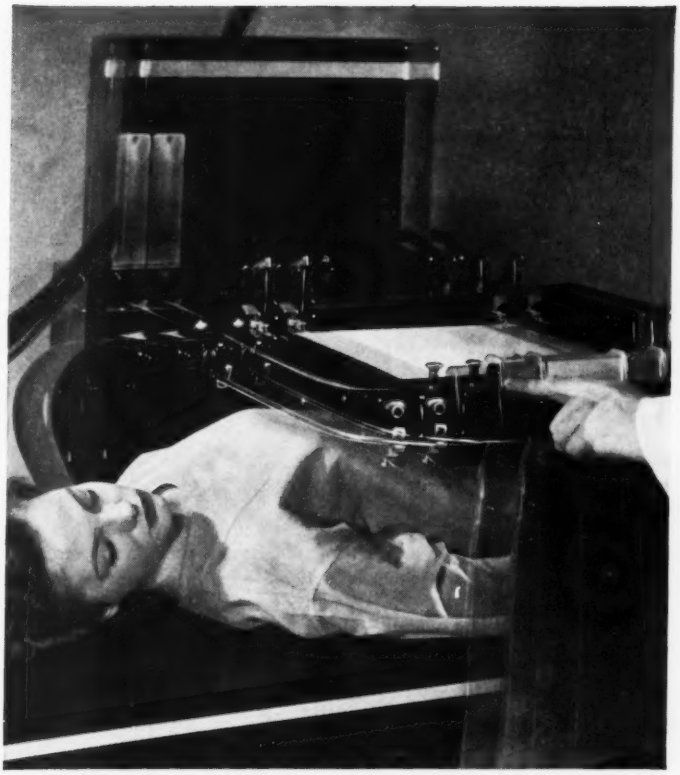
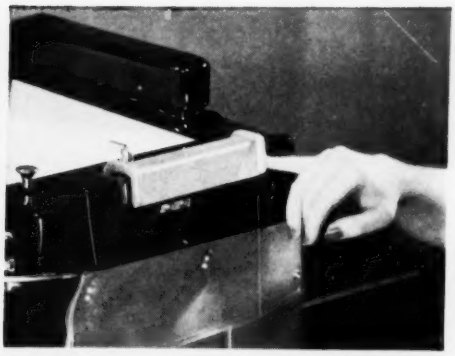
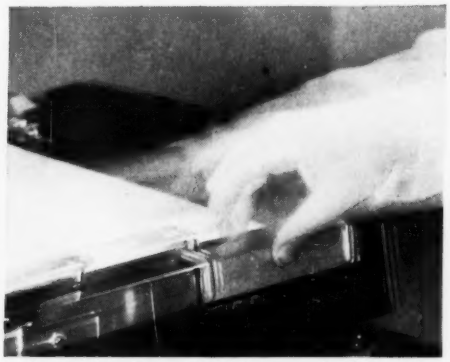


Photo shows fingertip control of screen and tower. Easy movement provides efficient and effortless operation for the radiologist.



Fingertip pressure unlocks and moves screen in one motion.



Action photo shows fingertip control with motion stopping smoothly.

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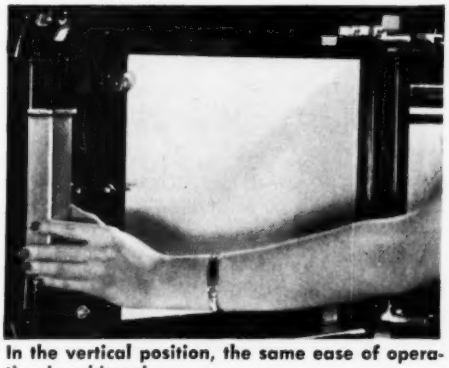

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NEWS...

F. T. C. Will Investigate Health Insurance Plan

WASHINGTON, D.C.—The launching of an investigation into the sale of hospitalization, health and accident insurance was announced here in December by the Federal Trade Commission.

The area of investigation will include practices used in the solicitation and sale of liability insurance, including protection for hospital, surgical and medical expense; loss of sight, limb and life, and loss of income owing to disability.

The investigation will also cover violations of the 1950 trade practice rules for mail order insurance companies, since the commission said it has information that "some were not complying with them and that this is to the disadvantage of the industry generally," as well as to the public.

The commission said it has received information that with some companies "certain practices may be prevalent . . . by insurers using the United States mails . . . resulting in buyers of such insurance being deceived by false and misleading representations as to the actual benefits payable thereunder."

Announcement of the investigation stated that no examination of intrastate companies which are regulated by authorities of the several states will be made but that "any matters brought to the commission's attention which are subject to state instead of federal law" will be referred to state officials.

TV Gets Into New Act: Makes Blood Count

NEW YORK.—A television device that completes a blood count in a few seconds, instead of the three to five minutes required by the best equipment previously available, was announced here last month.

The machine uses the usual blood smear on a glass slide under a microscope, it was explained, but a television camera is substituted for the human observer. The camera records blood cells and sends electrical impulses to a special counting device, which transmits the actual count to a meter.

The television device, called a Sanguinometer, was developed in cooperation with the Sloan-Kettering Institute for cancer research here.

NEWS...

Finance Commission Makes Its Report

(Continued From Page 52)

committees working in the fields of prepayment, financing hospital care for nonwage and low-income groups, and the costs of hospital care.

Starting with the principle that hospital care should be available as needed to all persons in the community without regard for their ability to purchase it, the Commission went on to explain the basis on which its recommendations were formulated: "Payment of the cost of hospital care is primarily the responsibility of the individual or family unit," the report stated. "The community should assume responsibility for payment only when the individual or family unit is unable to pay for care. Funds for financing hospital care for those who cannot pay for it should come from local community resources. State aid should be sought only when local need for supplemental funds is established; and federal assistance sought only when state inability to finance necessary care is determined."

Hospitals should continue to encourage philanthropic support by individuals, communities, corporations and foundations, the Commission urged, to meet deficits and to expand and improve facilities. "Philanthropy is preferable to the securing of needed funds for hospital services from tax sources," the report said.

Explaining its emphasis on the extension of voluntary prepayment coverage, the Commission pointed out that "the financial stability of the voluntary hospital system is becoming increasingly dependent on the degree to which voluntary prepayment enables both the general public and hospitals to meet their common problem of financing hospital care."

The hospital economy is inevitably endangered by any substantial rise in unemployment, the Commission noted. "Most voluntary hospitals would face a financial crisis with a substantial drop in levels of employment," the report said, adding that such a drop has not occurred in more than a decade. "The inadequacy of existing methods for financing hospital care for these nonwage and low-income groups is a major reason underlying the financial difficulties of America's voluntary hospital system."

In its studies of hospital costs, the Commission examined the financial operation of 1400 short-term, nonprofit general hospitals, it was reported. In 1952, income differed from expense by not more than 5 per cent in more than half of these hospitals. One-fourth of the institutions reported operating deficits, and 61 per cent would have had deficits if as much as 5 per cent of income had been earmarked for depreciation, replacement and improvement.

For the most part, the report indicated, deficits result from the attempt to provide comprehensive service. Thus deficits were reported most frequently in hospitals with 250 or more beds, and in hospitals where the number of ancillary services provided was greatest. Hospitals with deficits tended to have a longer patient stay than hospitals without deficits, higher expenditures per patient day, a higher ratio of employes to patients, and lower occupancy rates. "The existence of a deficit or surplus during a particular year is not an index of the effectiveness of the institution in meeting the needs of the community," the Commission asserted. "The most important factor affecting hospital costs is the nature of the hospital service program —its scope and quality. The hospitals with the most comprehensive service programs have the highest costs."

Analysis of costs among hospitals with a similar number of ancillary services revealed that hospitals meeting accrediting standards tend to have higher costs, higher pay-roll costs, and higher employe-patient ratios, it was reported. "As a group, hospitals which operated schools of nursing reported lower operating expenses per patient day, lower pay-roll expense per patient day, and a lower ratio of paid employes in relation to patients than did the group of hospitals without schools of nursing," the report stated. "These data suggest that in some hospitals the value of services provided by student nurses exceeds the expenditures for their maintenance and training. Numerous studies in individual hospitals have demonstrated conclusively, however, that the expenditures required to provide a high standard of training exceed the value of the services provided by the student nurses."

Approaching the problems of cost control, the Commission noted that if comprehensive service is to be pro-

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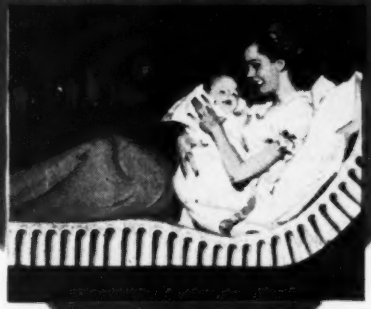

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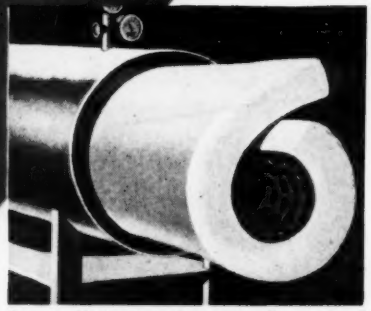

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vided at minimum cost to the public, there must be cooperation among hospitals to avoid duplication, as well as gaps, in hospital facilities and services. "If every hospital in the community offered a comprehensive service, without regard to community needs for such services, the total cost of hospital care to the public would be higher than necessary," the report said. "Joint study on a community-wide basis is required if the community is to have a coordinated hospital service protected against duplication." To effect integration, the Commission recommended regular meetings for discussion of common problems, sharing of skilled personnel, cooperation for in-service training, hospital mergers where indicated, and joint action and operation wherever possible.

Extension of outpatient service offers another means of controlling costs, it was pointed out. "Only by the development of service programs for ambulatory care can the hospital plant, equipment and personnel be most effectively utilized, thereby reducing unit costs to a minimum," the report said. "Utilization of hospital facilities and personnel may be achieved by calling the attention of physicians to the diagnostic facilities of hospitals available for ambulatory patients. In many hospitals, improvements in facilities for ambulatory services may be required if their utilization is to be increased."

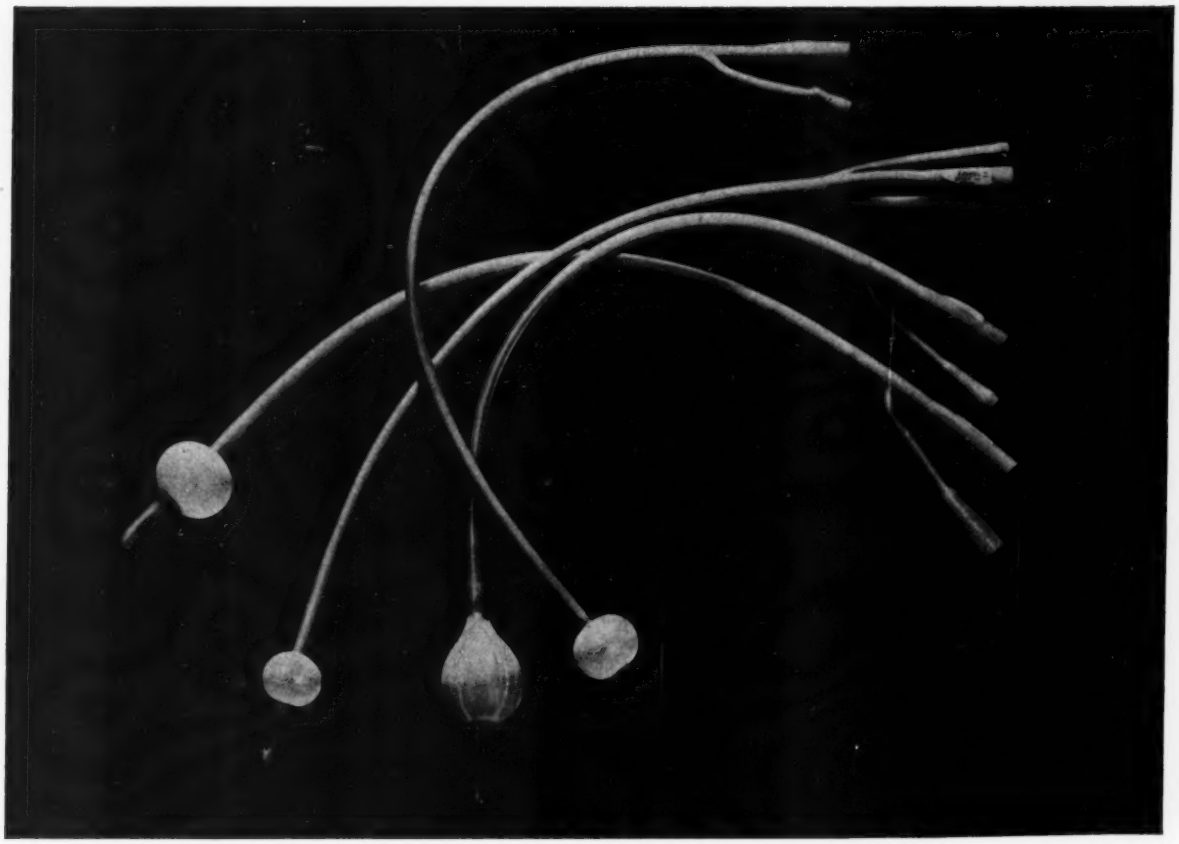
The following methods were suggested for expanding outpatient services as a means of reducing the overall cost of hospital care to the community:

1. Provision of special services to private ambulatory patients.
2. Provision of private offices for physicians.
3. Organization of diagnostic clinics.
4. Broadening of traditional clinic services.
5. Establishment of hospital group practice units.
6. Periodic physical examination programs.
7. Home care programs.
8. Coordination with nursing and convalescent homes, rehabilitation and other institutions.
9. Encouragement of prepayment programs including outpatient benefits and services.

In addition, the Commission recommended controlling costs through improved utilization of inpatient service and elimination of faulty utilization of hospital facilities and services. "Recognition by physicians of the economic factors involved in their use of hospital facilities and consideration of these factors together with the medical needs of the patient would do much to help reduce the cost of hospital care to the patient and the community," the report said. Doctors may aid in reducing hospital costs by the following steps, it was noted:

1. Obtaining necessary diagnostic data prior to the patient's admission.
2. Shortening duration of hospital stay wherever possible.
3. Avoiding unnecessary tests, treatments and other procedures.
4. Discontinuing drugs and therapy promptly when no longer needed.
5. Seeking consultations promptly when needed.
6. Preventing duplication of procedures already performed in the doctor's office.

The Commission also noted that cost



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control must be approached through improved budgeting practices, better utilization of hospital personnel at all levels, efforts to stabilize daily census, and other internal methods.

In its discussion of voluntary prepayment programs, the Commission noted the fact that hospitals often had difficulty collecting that part of the hospital bill not covered by prepayment benefits. "Too often, advertising and other sales promotion of prepaid hospital protection mislead the public on the adequacy of protection purchased," the report said. "As a result, a false feeling of security against the risk of hospital expense is created. At the time of hospitalization, when the inadequacy of benefit provisions is disclosed, public confidence in prepayment and in the hospital is lost when the level of protection purchased was misrepresented. The needs of the individual, the hospital, and the community are not met when the price for prepayment is set in relation to what will sell most easily, and when benefit provisions are also established on this premise."

With only a few exceptions, the Commission's recommendations were approved unanimously by the 34 member group, the report noted. Commission member E. J. Faulkner of Lincoln, Neb., president of the Woodmen's Accident Insurance Company, dissented from the recommendation for provision of hospitalization protection for beneficiaries of federal Old-Age and Survivors Insurance. "If the means test is used to establish need for financing hospital protection for O.A.S.I. beneficiaries," the dissent stated, "the proposal is unlikely of enactment because of congressional disinclination to include any means test in the O.A.S.I. system. On the other hand, if the means test is not included, many O.A.S.I. beneficiaries who do not need help to finance hospital care will receive an unneeded subsidy from the taxpayer. If government subsidizes hospital care for O.A.S.I. beneficiaries, precedent will have been established for similar subsidization of all health care costs, leading directly to socialized medicine. It is particularly unwise to extend O.A.S.I. benefits into any new fields at this time in view of the need for radical corrective measures to O.A.S.I. itself to prevent social security costs from becoming ultimately a crushing burden on our economy."

Exceptions to certain parts of the Commission's recommendations were also taken by the Commission's labor members, Stanley H. Ruttenberg, C.I.O., and Boris Shishkin, research director of the A. F. of L. Mr. Ruttenberg insisted that the Commission's findings had two major weaknesses, arising from "failure of the Commission to consider and recommend a comprehensive system of social insurance covering the costs of hospital care." The cost of belonging to voluntary prepayment plans, according to Mr. Ruttenberg's statement, which was released with the Commission report, "would continue to be too high for a large segment of the population." This results from an outstanding characteristic of the voluntary approach, he added, "namely, that members are charged the same amount, regardless of differences in earnings."

Mr. Shishkin's objection was that "no reference is made to the possibility that health insurance coverage should

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be placed on a comprehensive national base." In the recommendations, he said, "unwarranted stress is placed on confining the responsibility for remedies to the local community."

Emphasizing the fact that labor's meat is medicine's poison, precisely the opposite view was taken by another Commission member, Dr. Walter B. Martin of Norfolk, Va., president-elect of the American Medical Association. In connection with a recommendation stating that eligibility for public assistance for the medically indigent "must be established and administered in the local community," Dr. Martin asked that the report show his conviction "that the principle set forth in this point should apply whenever federal funds are used in connection with hospital care for the medically indigent."

In releasing its summary report, the Commission noted that full, detailed reports of findings and recommendations in the three principal areas of study would follow as rapidly as these could be published. "Inherent in the Commission's recommendations to the public is the need for further study and examination of the problems discussed," Gordon Gray, Commission chairman, said. "In every community and in every state representatives of the public, of hospitals, of physicians and of prepayment and other health and welfare agencies will need to test the Commission's recommendations in the light of their own particular problems. The lasting effectiveness of the Commission's work is dependent on such community action. We believe that our recommendations provide a basis for organized community action."

John Hayes of New York was director of study for the concluding phases of the Commission's two-year program, succeeding the late Dr. Arthur C. Bachmeyer, who became director a year ago when Graham Davis, the original director, retired because of ill health. Harry Becker was associate director throughout the study. The committee conducting the prepayment study was headed by Dr. George Baehr of New York; Rt. Rev. Msgr. Donald A. McGowan of Washington headed the committee on nonwage and low-income groups, and Dr. Robin C. Buerki of Detroit was chairman of the committee on costs of hospital care.

Electromicroscope Speeds Progress in Cancer Research

DURHAM, N.C.—An electromicroscope has been employed to count virus particles, and the new counting method has stepped up progress in cancer research at Duke University tremendously, it has been reported.

Under the new method, samples of unpurified blood plasma are "spun down" in a centrifuge; this separates out the virus particles, which stick to agar in the bottom of the test tube. The virus particles are then transferred from the agar to a liquid coating, collodion, and placed under the microscope where the particles are counted. By multiplying this count by the magnifying power of the instrument, the scientist learns how many virus particles are in the sample.

Duke scientists, using this method, have proved that a virus acts like an enzyme, *i.e.* it produces a definite chemical change in those parts of the body where an enzyme produces a similar chemical action.

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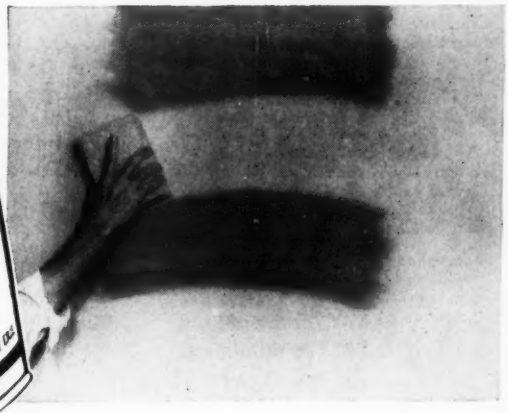

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NEWS...

Eisenhower Proposes Federal Aid for Health

(*Continued From Page* 72)

indicates that these voluntary organizations can reach more people and provide broader benefits. The government should not go into the insurance business to furnish the protection which private and nonprofit plans now provide, he said. "But the government can and should work with them to study and devise better insurance protection to meet the public need," he added.

Commenting on his recommendation to expand the Hill-Burton program, but with emphasis on facilities for chronic disease and other long-term illnesses, the President said: "Not all illness need be treated in elaborate general hospital facilities, costly to construct and costly to operate. Certain non-acute illness conditions, including those of our hospitalized aged people requiring institutional bed care, can be handled in facilities more economical to build and operate than a general hospital, with its diagnostic, surgical and treatment equipment and its full staff of professional personnel.

"If there were more nursing and convalescent home facilities, beds in general hospitals would be released for the care of the acutely ill. This would also help to relieve some of the serious problems created by the present short supply of trained nurses."

The President placed the need for additional beds in all facilities, including those for chronic, mental, tuberculous and other long-term patients, at 500,000.

Noting that many illnesses can be cared for outside of any institution, the President recommended, as "a far less costly approach to good medical care than hospitalization," construction of diagnostic and treatment facilities for ambulatory patients.

The President's program plainly reflected the view that too many people in the nation can't get or can't afford adequate medical and hospital care. "Even where the best in medical care is available," he said, "its costs are often a serious burden. Major, long-term illness can become a financial catastrophe for the normal American family."

The President's concept of "socialized medicine" was suggested in his proposal that the government should encourage and work with existing voluntary organizations and programs, rather than conducting its own prepayment program. Furthermore, he added, "we should continue to observe the principle of state and local determination of needs without federal interference."

House Committee Hears Experts on Health

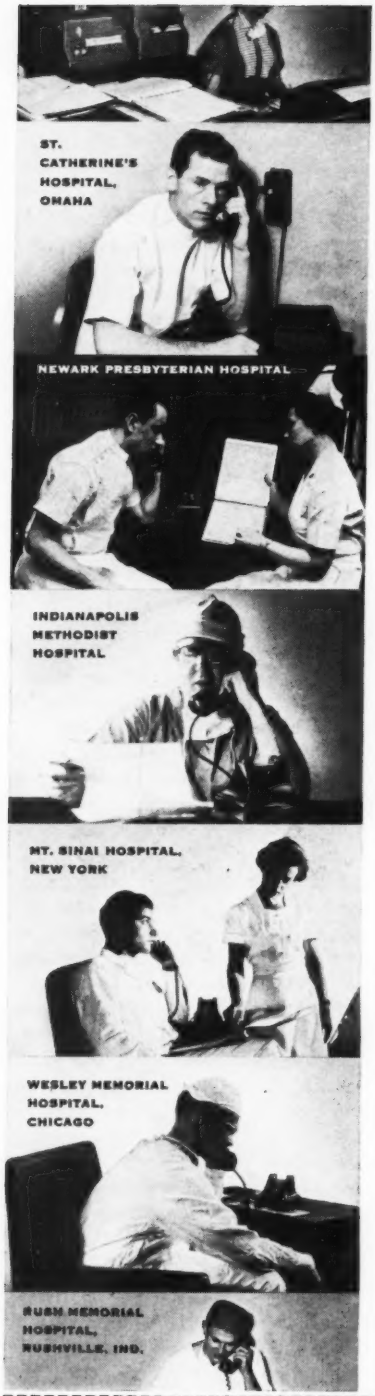
(*Continued From Page* 72)

pital construction, government assistance for development of group medical practice, subsidies for voluntary health insurance plans to promote broader coverage at low cost, health insurance loans for low-income families, and a national system of insurance for catastrophic illness.

"Of course, such a program as assistance to low-income families will entail cost to the government," Mr. Hayes told the committee. "But when we discuss the cost of taking care of our health problem we must be constantly aware of the fact that we do not avoid cost by failing to deal with the problem. It is not a question of whether or not we pay for our health —but of how we pay, and what we get in return. The loss of time, manpower, production and income that results from illness, physical deficiencies and premature death is a total loss. Society stands to gain, in financial as well as human values, by solving the problem."

Another witness at the hearings, Henry J. Kaiser, industrialist and president of the Kaiser Foundation, supported the principle of Rep. Wolverton's bill to provide insurance for loans that would stimulate investment of private capital in the construction of health facilities. Describing the Kaiser Foundation's health plan, under which 400,000 members are receiving hospital and medical care at the Foundation's Pacific Coast hospitals and clinics, Mr. Kaiser proposed what he called "a private enterprise solution," which would enable 30,000 doctors throughout the country to provide voluntary, low-cost prepaid medical and hospital care to 30,000,000 Americans. His system, Mr. Kaiser stated, would make government socialized medicine "absolutely unnecessary."

American doctors can bring about such a "free enterprise solution to the



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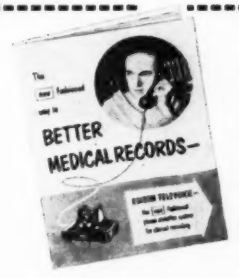

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high costs and tragic hazards of illness" by carrying out four basic principles, Mr. Kaiser stated. These were: (1) prepayment of doctor and hospital bills by periodic dues; (2) group practice of general physicians and specialists; (3) integrated medical centers and clinics that can be self-supporting without subsidies, and (4) emphasis on preventive medical care and early detection of disease.

Under the Kaiser system as it was described to the committee, groups of doctors would be encouraged by federally insured mortgage loans to establish group practice units recognizing these four principles. "The investment of approximately one billion dollars, entirely through private funds, could finance the building of medical centers in every part of the country, providing hospitalization for the 30,000,000 Americans and the care by 30,000 doctors. These facilities could pay for themselves and be completely self-supporting," he declared.

In a long, prepared statement, Mr. Kaiser described the various services and facilities of the Kaiser Foundation in California. "We are vitally interested in the development of similar plans and services all over the United States," he concluded, "to the end that comprehensive care on a group practice, voluntary prepayment basis is made available at reasonable cost to all our people. What has been accomplished and is being accomplished by us can be done in other areas of the country. This committee might well consider exploring the ways in which the federal government could encourage and stimulate the development of voluntary medical service plans—plans which could provide comprehensive care at reasonable costs on a group practice basis in affiliated hospitals and medical centers."

Opening the committee hearings, Chairman Wolverton had criticized the American Medical Association for branding various public health proposals as socialized medicine but not submitting any comprehensive health plan of its own. "Whenever legislation is proposed which would prove helpful to the average citizen," Rep. Wolverton stated, "too frequently the charge is made that it is socialized medicine. We have a right to expect that criticism should be constructive and helpful. I fail to find any solution that is offered by the A.M.A."

State and county medical societies are a serious obstacle to the development of prepayment plans and group practice, Dr. George Baehr, president of the Health Insurance Plan of Greater New York, told the Wolverton committee. The American Medical Association has accepted prepayment and group practice, Dr. Baehr said, but state and county medical societies do not always follow suit.

"A widespread spirit of intolerance to change pervades the thinking and actions of their leaders," Dr. Baehr said, "and in some states laws have been enacted at the instigation of medical societies which actually prohibit prepaid group practice."

For example, Dr. Baehr testified, H.I.P. is denied use of necessary advertising because of a ruling made by the New York County Medical Society, although, he added, "the public has a right to know of the existence of any plan."

The doctors' antipathy toward group

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NEWS...

practice has been subsiding, however, Dr. Baehr related. Most group practice units now have waiting lists of young doctors wanting to join, he reported. In response to a question from a member of the committee, Dr. Baehr said opposition to prepayment and group practice comes principally from physicians in urban areas who are interested only in their own practices. This type of physician, he said, "has no interest in social improvement or advancement of the community. They have adequate means and they elect people to the county medical societies who will carry out their wishes."

Hearings on Rep. Wolverton's health bills were expected to continue into February, with a number of national medical, hospital and prepayment authorities scheduled to testify.

Cost of Educating Nurse at College Being Studied

NEW YORK.—A project to develop a method of determining the cost of basic nursing education programs in colleges and universities was announced here recently by the National League for Nursing.

Participating in the study will be the school of nursing of the University of Washington, Seattle; department of nursing, Loretto Heights College, Denver; school of nursing, University of California, Berkeley, and school of nursing, Emory University, Atlanta, Ga. A pilot study has been made at Skidmore College, Saratoga Springs, N.Y.

Agnes Gelinas, professor and chairman of the department of nursing at Skidmore, and chairman of the project committee, said, "The N.L.N. is repeatedly asked, 'What is the cost of nursing education?' The answer is imperative in planning for nursing education, in providing facilities, and in building adequate support. Our study proposes to work out procedures for determining costs and for testing the feasibility and practicability of such methods."

Although the study is being made in collegiate schools, the association has said that the working and advisory committees believe that methods worked out may also be applicable to hospital schools.

At a later date, additional schools will be asked to participate in certain sections of the study, the N.L.N. said.

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NEWS...

Dr. Kogel Summarizes Achievements, Failures in Department of Hospitals

NEW YORK.—A few days before leaving the department, Dr. Marcus D. Kogel, commissioner of New York City's hospitals for five years, whose recent resignation became effective January 1, addressed a "valedictory" letter to retiring Mayor Impellitteri in which he criticized the city's budget and civil service system and extolled its hospital construction program.

Dr. Kogel said the construction program "is doubtless the most ambitious venture of this sort ever undertaken by a municipality," having opened 3218 beds since 1950 and closed 1975 obsolete beds. In addition, $110,000,000 worth of facilities representing 4206 beds are now in construction, he said. Although he is pleased about the construction, it is the type of construction that is important, according to Dr. Kogel— treatment, research and teaching facilities in addition to a flexibility which would meet any foreseeable change in the city's disease pattern.

The former commissioner congratulated his department on the improved methods of medical care which introduced such technics as home care, reduced the overcrowding in hospitals, ended the waiting lists for TB admissions, improved outpatient departments, and started the boarding out of aged patients.

Dr. Kogel considered his inability "to obtain adequate salary adjustments for the professional and technical workers of the department" as his "greatest failure." "We are able to carry on only because so many of our key people are held captive by the city pension system," he said. "The time is almost here when the retirement of pathologists, roentgenologists, medical, nursing and dietary administrators and others in professional and scientific fields will weaken the hospitals of the department so that it will be hardly possible to maintain decent standards of care," Dr. Kogel warned.

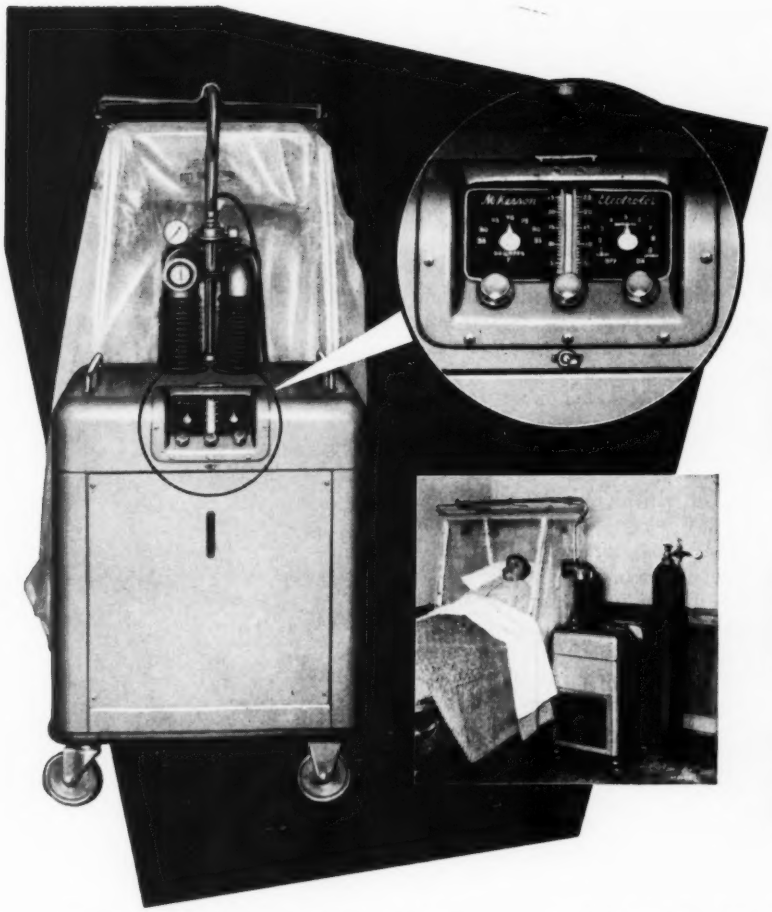
Looking to the future in the light of the present, he said, "Desperate shortages in critical personnel categories have already forced us to lower standards. We have had to remove physicians from the emergency ambulance service of the city and we have had to substitute subprofessional for professional personnel in many areas of hospital operation.

"We are prompted by necessity to employ large numbers of unskilled workers in patient care, and this multiplies many times the need for supervisory and training people. It would be tragic indeed if this situation goes unrecognized until a calamitous occurrence spotlights too late a serious deficiency in supervisory staff," Dr. Kogel concluded.

Cost Study Completed

NEW YORK. — A 543 page study of the various types of prepaid hospital, medical and surgical plans has been completed at Columbia University under a $92,000 grant from the Health Information Foundation of New York.

The study was directed by Oscar N. Serbein, assistant professor of statistics at the university's graduate school of business. The report is called "Paying for Medical Care in the United States."



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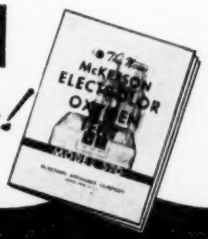

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NEWS...

Teachers College Establishes Program of Training for Nursing Consultants

NEW YORK. — Major increases and changes in the nation's medical and health needs confront the nursing profession with serious new responsibilities, according to R. Louise McManus, director of the Division of Nursing Education at Teachers College, Columbia University.

The acute shortage of professional nurses, for example, is causing many hospitals, clinics and other agencies, including nursing schools, to reorganize their nursing service and to base training on new and improved concepts of patient care, Miss McManus asserts.

The need for these and other changes in service and education has pointed up the importance of nursing consultants, who are being increasingly called on for major aid in planning basic revisions and guiding new programs. To meet the growing demand for qualified nursing consultants, the Division of Nursing Education at Teachers College has established a special program for preparing experienced nurses for these positions.

The program, which started last fall, is a pioneer effort in nursing education and is said to be the first to be offered at the college or university level. It was developed at the request of practicing nursing consultants, hospitals and other health agencies as a full training program in this field of consultancy.

"Many nursing consultants are now serving hospitals, industry, schools, public health units, and state and federal departments of health and welfare," Prof. McManus declares. "But consultant service in nursing, as in business, industry and government, is often provided by people who, although highly trained and experienced in their fields, are only self-trained for the specific skills of consultation work."

Nursing consultants who have met in conferences at Teachers College and other universities have felt that a formal academic program would provide the profession with better consultants in a shorter period of time, Miss McManus says. The Teachers College program is based on recommendations of professional nursing consultants and on research by business and industry on the importance of consultants.

(*Continued on Page* 179)

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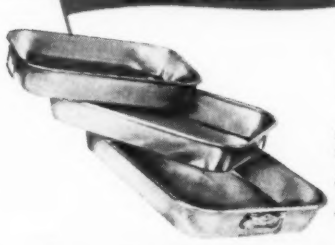

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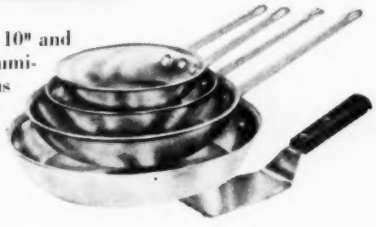

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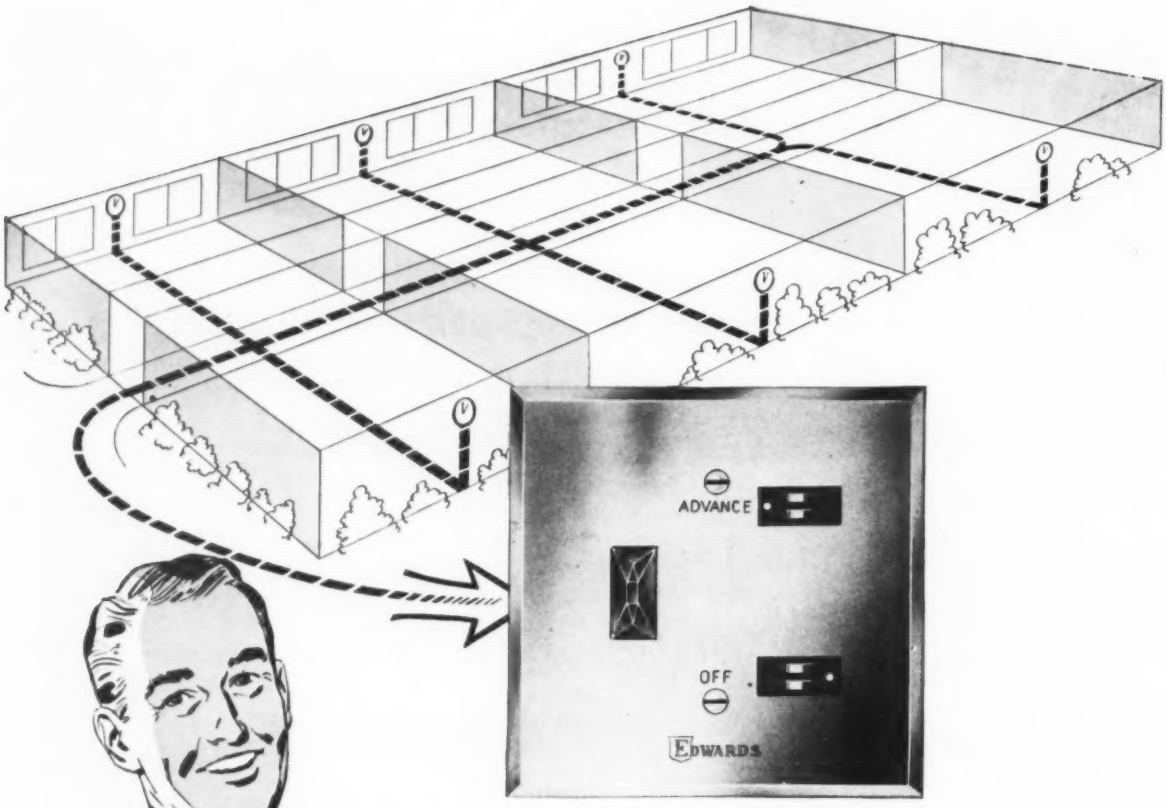

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NEWS...

(*Continued From Page* 176)

Designed for experienced nurses, the program at Teachers College is emphasizing, first, a practical knowledge of consultation technics through seminars and field work and, second, a thorough knowledge of one specialized nursing area.

Seventeen registered nurses, who are specialists in some phase of nursing — public health, pediatrics, surgical, cardiovascular and others — are now enrolled in the experimental program, which is under the direction of Profs. Ruth Gilbert and Margaret Adams of the nursing education faculty.

The program is designed to meet the five major qualifications of a nursing consultant: full preparation in a clinical or special area; broad understanding of the issues, problems and social setting of the profession; adeptness in analyzing problems; skill in communicating with others; skill in finding and using research materials and, at times producing them.

The students are taking two seminar courses over an 18 month period. One, on the principles of consultation work, is based on research in many non-nursing fields on the relationship of the consultant to the sponsoring agency and to his profession. The other seminar is taking up problems in special nursing situations.

At the end of their academic training, students will be assigned to field "internships" in their own or in allied nursing specialties. Working closely with a practicing field consultant, the student will, at the beginning of field study, work alongside the experienced consultant.

"As the student-consultant gains more ease and experience in dealing with people, she may do actual consultation under supervision," according to Prof. McManus.

Related courses, which form the program as a whole, are geared to the individual backgrounds of the student. Some students need experience in research technics, others need a broader background in the social sciences, in working with groups, in the broad issues and trends in nursing, or they may require additional advanced work in their own nursing specialities. The division's policy is to encourage students to take courses at the college or Columbia University necessary to become qualified consultants.

Nurses who enroll in the program are required to have a bachelor's degree and about five years' nursing experience, at least two years of which is in supervision, administration or teaching of nurses.

Expanding consultant service in all fields has led to research showing there are technics and human-relations factors common to all consultants. Whether a qualified pediatric nurse, for instance, is required to work with groups of nurses or advise a government agency in establishing a statewide program affecting children's health, the basic consultant methods are similar.

The faculty members in charge of the 11 fields of specialization in the new consultation program are Prof. Margaret Adams, pediatrics; Francis Kreuter, administration and in-service education; Prof. Bernice Anderson, administration of nursing education; Bess Ellison, tuberculosis; Prof. Gilbert, mental hygiene; Lydia Hall, long-term illness and cardiovascular disease; Prof. Kate Hyder, maternity; Louise Smith and Eleanor Lambertson, supervision in nursing; Prof. Eugenia Spalding, curriculum and teaching; Elizabeth Stobo, Miss Smith and Frances Frazier, public health nursing, and Mary F. Liston, psychiatric nursing.

The Teachers College nursing division is one of four institutions in the country to offer a mental hygiene consultancy in cooperation with the U.S. Department of Health, Education and Welfare. The others are Johns Hopkins University, the University of Minnesota, and Catholic University of America.

The consultants' purpose is not primarily to work directly with patients, but to reach, through group work and individual conferences, the largest possible number of nurses in various health agencies. The consultant finds out what the nurses themselves want to know —where their "special needs" in mental hygiene work with patients and families may lie—and offers her help accordingly, rather than devising an educational program and superimposing it on them.

"If, however, a more highly organized educational program is desired by nurses within an agency or community, the mental hygiene consultant can conduct or arrange such a program," Prof. Gilbert explained.

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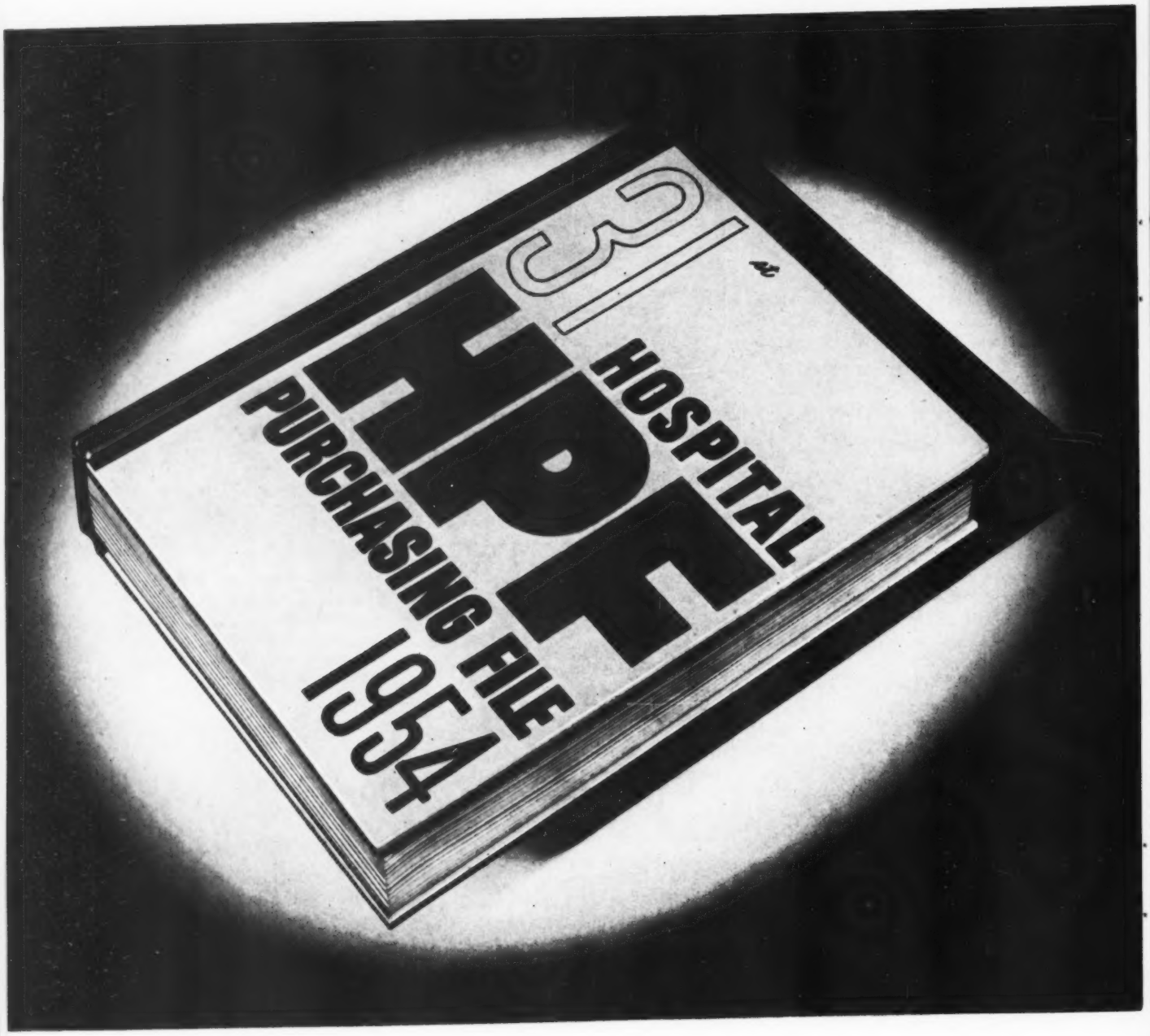

NEWS...

Special Unit for Elderly Patients to Be Built at Iowa Methodist Hospital

DES MOINES, IOWA.—A "large sum" of money (amount and donor unannounced) has been given to Iowa Methodist Hospital here toward establishing a center for the treatment of the elderly sick, Donald W. Cordes, administrator of the hospital, announced last month.

The money will be split three ways, according to the donor's wishes: (1) 20 per cent for educating doctors, nurses and therapists in the special care of patients with chronic illnesses; (2) 40 per cent to be set aside for successful economic operation of the unit; (3) the other 40 per cent for remodeling Iowa Methodist Hospital or for construction of a new building to house the special facilities required.

According to the *Des Moines Tribune,* this will be the first such geriatric unit in Iowa, although a similar unit is in the planning stage at Jennie Edmundson Memorial Hospital, Council Bluffs.

"The gift is sufficiently large, if matched with Hill-Burton funds in the state, to make possible the construction of a really good chronic disease unit in connection with our general hospital," Mr. Cordes declared on January 15.

Mr. Cordes and the donor do not look upon the proposed unit as a nursing home or a home for custodial patients. The emphasis will be upon rehabilitation, and the average length of stay is estimated at 60 days. The patients' own doctors will continue to treat them in the proposed new unit with the aid of physical therapists and specialists.

Adds Two-Year Course in Institutional Purchasing

NEW YORK.—Columbia University's School of General Studies has added a two-year program in institutional management, especially designed for institutional purchasing agents, to its curriculum, Louis M. Hacker, dean of the university's liberal arts school for adults, announced here last month.

Hospital, education and hotel professional organizations have participated in the development of the curriculum which will provide specific types of training for purchasing and department heads.

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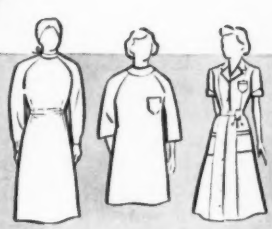

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NEWS...

Hospital Liability Laws in Britain Are Changing

LONDON, ENG. — In Britain the law regarding hospitals and their liability for negligence seems to be changing, C. J. Hamson, a lawyer, declared recently in a talk over BBC's "Third Programme."

This change, Mr. Hamson declares, is connected with a change in the conception of the function and duty of hospitals. Such a change has "large and important social implications which are only partially and incidentally reflected in the law."

To prove this point of the changing concept of the courts toward hospital negligence, Mr. Hamson first cited the case of Jones *v.* Manchester Corporation et al., now on appeal to the House of Lords.

In this case the plaintiff's husband suffered minor burns on the face. He was seen by the house surgeon, assisted by a "very recently qualified young woman." They decided to give him a minor anesthetic—gas—in order to clean up his face. This was a miscalculation as after they started the job they found that the mask covered the part of the face they wanted to treat.

With the patient on the table and unconscious, the doctors switched to pentothal, said to be highly dangerous to an unconscious patient. The man, who had come to surgery hale and hearty, died on the operating table. In this case the individual responsibility of one or more determinate persons could be established fairly easily.

However, in another type of case, represented in Mr. Hamson's argument by the case of Cassidy *v.* Ministry of Health, the plaintiff may be able to regard the hospital as a closed system, as a factory in which a process is taking place. "If responsibility for that process as an entirety vests in the factory occupier, the hospital managers, then all the plaintiff has to show is that something has gone wrong somewhere in the process—that the process properly conducted would not have resulted as it has." The plaintiff no longer cares whether it is precisely the radiologist, the pharmacist, the nurse, the surgeon or even the plumber or the cook who has gone wrong.

Moreover, as Mr. Hamson pointed out, when the argument is lifted to a more scientific plane and is about the process as a whole, "individual doctors

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4 The Medi-Kar rolls to the patient's bedside and the nurse selects either oral or hypo medication without delay. Everything she needs is provided — even fresh water, glasses and a tray for soiled syringes. This procedure is repeated for as much as an entire nursing section with complete safety and efficiency.

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NEWS...

find it easier to say that something must have gone wrong; for then they feel themselves speaking about their science (of which they tend to think well) and not about the culpable lapse of any one personal colleague, which obviously is an awkward matter."

The Cassidy case was that of a laborer who suffered from a contraction of the third and fourth fingers of his left hand. His doctor sent him to the hospital for treatment. He was operated on and his hand and lower arm were put in a splint for two weeks. Mr. Cassidy spent the two weeks in the hospital but he kept complaining to the nurses about severe pain, and also to the house surgeon and to the assistant medical officer. They considered him the sort of male who can't bear any pain and did nothing. When the splint was removed, all four fingers, instead of the original two, were found to be permanently and irremediably useless.

In the action for negligence that followed, the trial judge entered judgment for the defendant, the hospital, on the ground that the plaintiff had failed to prove negligence on the part of any particular member of the hospital staff.

The court of appeals reversed the judgment of the lower court and held, first, that the hospital was liable for the possible defaults of all the persons concerned—for the assistant medical officer and the house surgeon and the nursing staff. Second, it held that *prima facie* case of negligence had been established against the hospital taken as a whole, upon proof simply of the resulting injury to the hand, upon the ground that the operation and treatment, if properly conducted, would not result in the destruction of the hand.

Of course, said the court of appeals, in a proper case the hospital might rebut the *prima facie* case by showing how and why (without negligence on the part of its servants) the hand had been destroyed, but in this case the hospital had not done so. In these circumstances, as one of the judges said, "it is not necessary for the plaintiff to establish precisely which individual employe was negligent."

Now, said Mr. Hamson in commenting on the case, "what is critical is that by holding the hospital managers to be in control of the treatment as a whole, the court of appeal has in

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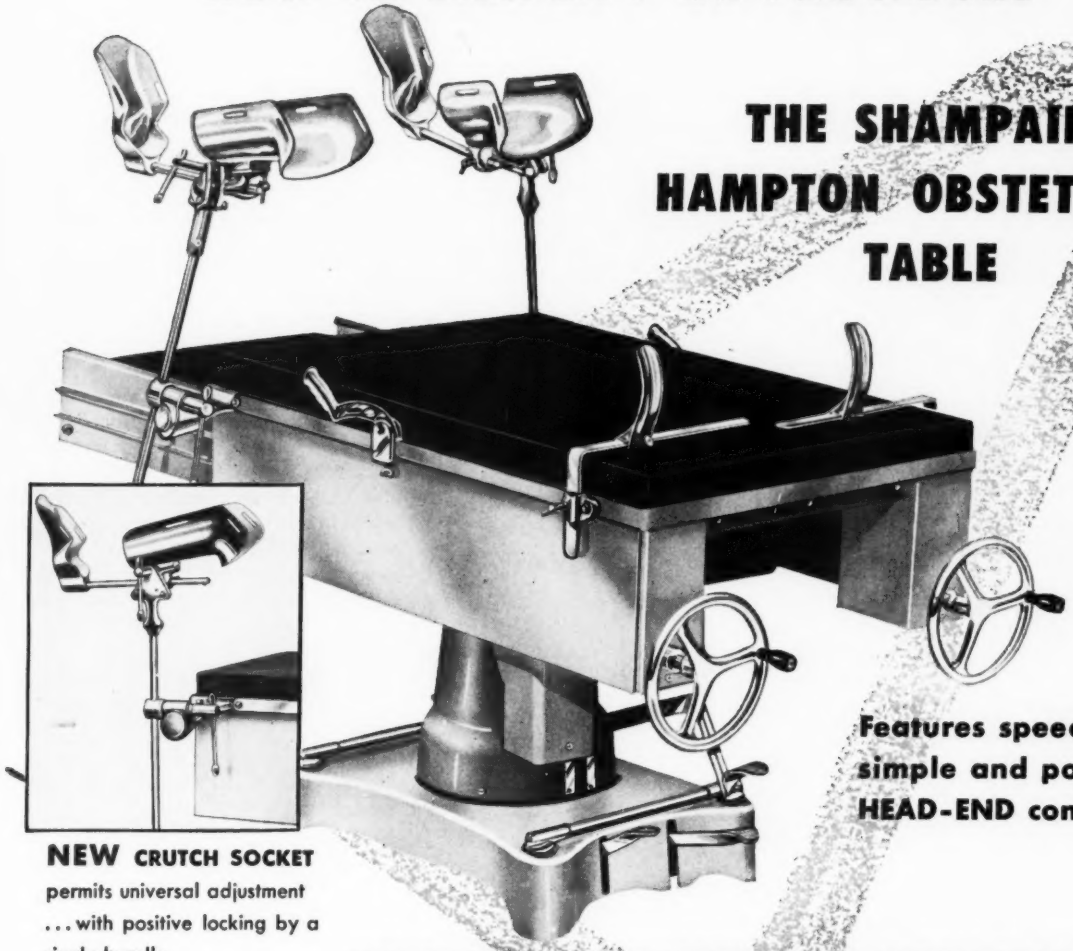

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effect reversed the burden of proof. Under circumstances such as these it will now be more incumbent upon the hospital to show, if it can, how the damage could have happened in spite of proper medical attention than for the plaintiff to prove who in particular has behaved culpably.

The Cassidy case is important, in Mr. Hamson's mind, because it crystallizes an element already implicit in previous British cases—the tendency to think of a hospital as a closed system for which as a whole the hospital managers are responsible. The failure to treat the patient adequately might be construed as the personal default of the managers.

In summing up his views of the changing status of the British hospital in cases of liability for negligence, Mr. Hamson states:

"The normal hospital as at present constituted physically cannot show toward each of the crowd of patients pouring in upon it that skill and care which the medical art, considering the patient individually, might specify as appropriate to the patient. But if we penalize a hospital for failing to attain that standard, are we not saying that it *should* attain that standard? And does not *should* for most people in this context imply that the hospital *could* attain it, at least if it showed consummate diligence? Is not the law encouraging an unreal view of the facts—though maybe it is a pious fraud—when it penalizes a hospital for failing to attain a standard which it cannot attain? And is it not socially dangerous to encourage even a pious fraud?

"Or should it be argued on the contrary that by penalizing a hospital for failing to attain in the particular case a standard which it may be exceedingly difficult or even impossible to attain in all cases, the law helps to promote the habitual attainment of a somewhat higher standard of practice, as has undoubtedly been the result of the 'safe system of work' formula in factories?"

Mr. Hamson, in conclusion, declined to try "to resolve questions of that order."

New York Contemplates Bond Issue to Finance Mental Hospital Expansion

ALBANY, N.Y.—An expansion and modernization program for New York State's mental institutions is under consideration by Gov. Thomas E. Dewey and his advisers, according to a December report of the *New York Times*.

Having been informed by budget officials that it will cost $30,000,000 a year for new construction just to keep up with the increasing number of patients without replacing outdated facilities or ending present overcrowding, the governor is considering a bond issue of $300,000,000 to $500,000,000. The money would have to come from tax money now earmarked for the war bonus fund.

The war bonus money is drawn from a one cent tax on each package of cigarets sold and 10 per cent of the full rate of personal income tax. This revenue in the present fiscal year is estimated at nearly $59,000,000, while only about $32,600,000 of it is needed to finance the bonus bonds, according to the *New York Times*.

Authorization of the bond issue would require the approval of the leg-

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NEWS...

islature as well as the voters in next fall's election.

The 112,000 resident patient population of the state's 27 institutions for mentally ill persons represents an overcrowding of about 30 per cent, it is estimated.

Although no formal commitment has been made to proceed with the bond issue, state officials were reported as deciding that there was no other way to add buildings, end overcrowding, and replace outmoded facilities.

COMING EVENTS

AMERICAN ACADEMY OF GENERAL PRACTICE, Public Auditorium, Cleveland, March 22-25.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Chicago, Sept. 11-13.

AMERICAN DIETETIC ASSOCIATION, Commercial Museum and Benjamin Franklin Hotel, Philadelphia, Oct. 26-29.

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference, Chicago, Feb. 5, 6; Navy Pier, Chicago, Sept. 13-16.

AMERICAN MEDICAL ASSOCIATION, San Francisco, June 21 to 25.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Regional Meetings: Stoneleigh Hotel, Dallas, Tex., March 26, 27; President Hotel, Kansas City, Mo., April 5, 6. Annual Meeting: Hotel Baker, Dallas, Tex., Oct. 21-Nov. 3.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 10-12.

AMERICAN SURGICAL TRADE ASSOCIATION, Grand Hotel, Mackinac Island, Mich., June 7-9.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-13.

ASSOCIATION OF WESTERN HOSPITALS, Hotel Statler, Los Angeles, April 26-29.

CALIFORNIA HOSPITAL ASSOCIATION, Fresno Hacienda, Fresno, Oct. 28, 29.

CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Va., April 29, 30.

CATHOLIC HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, N.J., May 17-20.

CONFERENCE OF CATHOLIC SCHOOLS OF NURSING, Atlantic City, N.J., May 15, 16.

INDIANA HOSPITAL ASSOCIATION, Institute on Legal Aspects of Hospital Administration, Student Union and Food Service Building, Indiana University Medical Center, Indianapolis, April 8-9; Student Union Building, Indiana University Medical Center, Indianapolis, June 10, 11.

IOWA HOSPITAL ASSOCIATION, Annual Meeting, Savery Hotel, Des Moines, April 21.

KANSAS HOSPITAL ASSOCIATION, Wichita, Nov. 12, 13.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Seelbach, Louisville, April 20-22.

LOUISIANA HOSPITAL ASSOCIATION, Baton Rouge, April 29, 30.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 8, 9.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 26-28.

MIDWEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo. April 28-30.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Biennial Congress, Drake Hotel, Chicago, June 2-5.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 29-April 1.

NEW YORK STATE DIETETIC ASSOCIATION, Albany, April 29, 30.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 29-April 1.

SOUTHEASTERN ASSEMBLY OF NURSE ANESTHETISTS, Atlanta, Ga., April 7-9.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 7-9.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Greystone, Gatlinburg, Tenn., May 20-22.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 18-20.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 3-5.

UPPER MIDWEST HOSPITAL ASSEMBLY, Hotels Lowry and St. Paul, St. Paul, May 12-14.

WISCONSIN HOSPITAL ASSOCIATION, Milwaukee, March 18.

NEWS...

N. Y. Council Urges Expansion of Hospital Instead of New Unit

NEW YORK. — After considerable study of the bed needs of the Bedford-Stuyvesant area in Brooklyn, N.Y., the Hospital Council of Greater New York recommended the expansion of Cumberland Hospital rather than construction of a new city-owned facility. Bedford-Stuyvesant is a Negro-white section of Brooklyn of about 233,000 population.

It was the opinion of the council that an addition of 125 general care beds would accomplish three objectives: (1) It would increase the beds available to residents of Bedford-Stuyvesant in a number sufficient to satisfy their unmet needs; (2) it would attain this objective with the greatest economy in the use of community funds, and (3) it would further continued effective utilization of the community's investment in hospital facilities and programs now in existence.

However, before he left his position as commissioner of hospitals, Dr. Marcus D. Kogel took issue with the council, saying, "I think this is one time when they're terribly wrong."

Dr. Kogel pointed out that the hospital built in early 1920 lacks essential service facilities. He maintained that in the long run the city would save money by building the proposed Bedford-Stuyvesant Hospital to "decompress" the Brooklyn municipal hospitals and eventually to replace Cumberland Hospital.

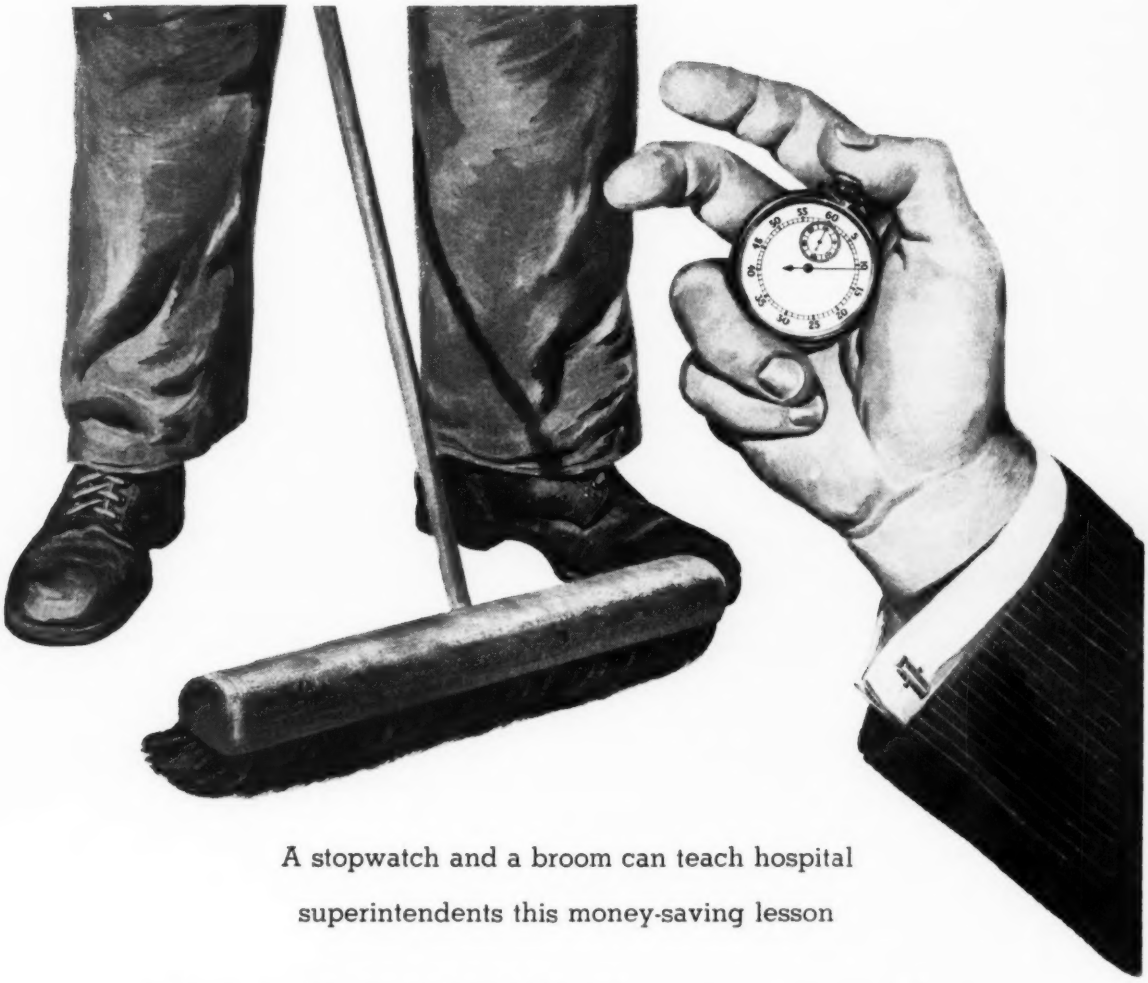
Included in its recommendations to city officials was a statement by the council relating to staff privileges. "Boards of trustees of the voluntary hospitals and the commissioner of hospitals of the city of New York should take steps to provide hospital staff appointments for all practicing physicians, Negro or white, without discrimination. The extent of the hospital privileges accorded to a physician should depend upon his training, experience and competence, not upon his race or color," the council recommendation stated.

Grand Jury Investigates Thefts at State Hospital

KANKAKEE, ILL.—Reporting its investigation of thievery at the Kankakee State Hospital, the Kankakee County grand jury last month criticized the state welfare department but failed to indict any of the hospital employes accused of theft.

Noting that public property of "substantial value" had been stolen by state employes over a period of 12 years, the grand jury criticized investigators from the state welfare department for failing to get dates and times of thefts and other positive evidence. Investigations had determined that hospital employes were pilfering state property amounting to an estimated total of $250,000 a year. Property thefts included bed sheets, soap, pillow cases, blankets, clothing and foods, it was indicated.

Following its investigation, the grand jury also recommended separation of administrative and medical departments in all state institutions and construction of a new central kitchen for the Kankakee hospital. The jury commended Dr. Otto Bettag, state welfare director, and Dr. Ernest Klein, hospital superintendent.



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NEWS...

Western Reserve Offers Extension Course for Head Nurses in Canton

CANTON, OHIO. — An extension course designed to help the graduate nurse prepare for the position of head nurse will be inaugurated here this month under the auspices of Western Reserve University School of Nursing.

A 17 week course in ward administration, it will be offered for registered nurses now employed who are unable to enroll in regular courses on the Cleveland campus. Classes will be held at Mercy Hospital School of Nursing.

Sessions will emphasize administrative, supervisory and teaching responsibilities of the head nurse which enable her most effectively to meet the needs of patients and hospital personnel.

Three semester hours of credit toward the degree of bachelor of science in nursing may be earned by nurses enrolled in the course, although the class does not necessarily have to be taken for credit, according to an announcement by Western Reserve.

Copeland Reelected Head of St. Louis Council

ST. LOUIS.—C. E. Copeland, administrator of the Missouri Baptist Hospital here, was reelected president of the Greater St. Louis Hospital Council at its annual meeting last month.

Other officers elected by the group were: first vice president, Mrs. Addie Mullins, Christian Hospital; second vice president, Sister M. Brendon, St. John's Hospital; secretary, Mrs. Cornelia S. Knowles, McMillan Hospital, and treasurer, Elmer V. Mosee, Peoples Hospital. Members of the executive committee are Dr. David Littauer, Jewish Hospital; Dr. A. J. Signorelli, Faith Hospital, and Sister M. Columbian, Incarnate Word Hospital.

During a panel discussion on hospital volunteers, Mrs. Harry Wurtenbaecker of St. Louis Children's Hospital recommended a paid director in charge of the hospital volunteer program. She defined the ideal volunteer as "one who agrees to work without remuneration, but having made the agreement works with the same degree of responsibility as the paid worker."

Episcopal Hospital Plans Nine-Story Addition

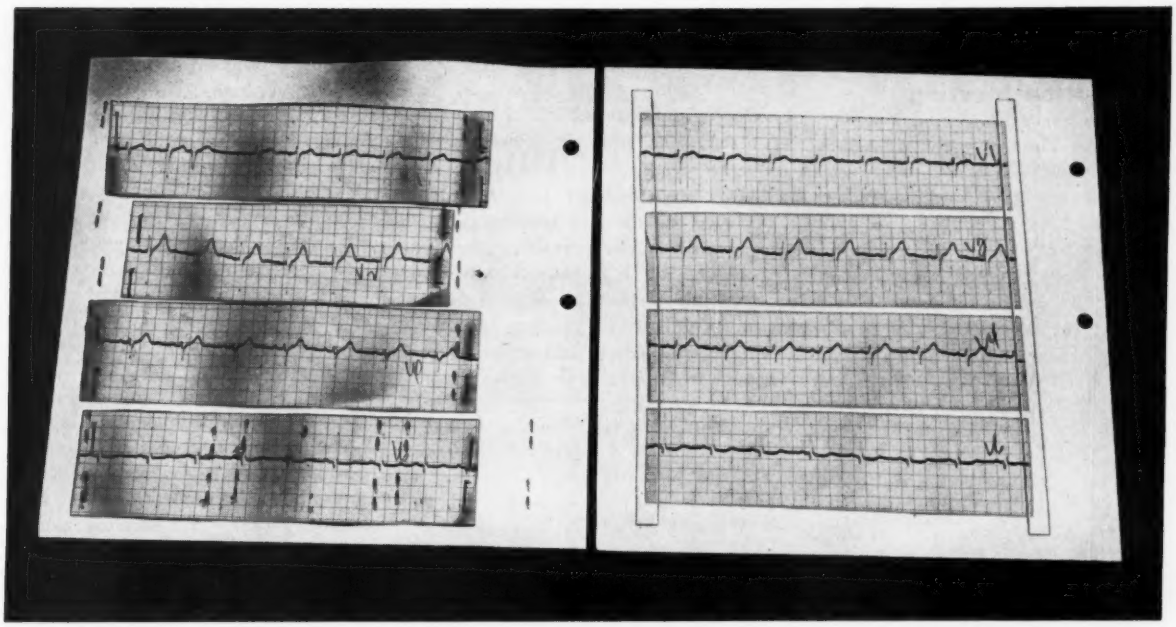
PHILADELPHIA. — Construction plans for a nine-story addition to Episcopal Hospital here have been announced by R. Alexander Montgomery, president of the hospital's board of managers.

Incorporating the hospital's operating rooms, x-ray department, laboratories, kitchens and central supply room into the new wing will enable the hospital to expand and modernize departments now operating under difficulties, said Mr. Montgomery.

The new addition will also house a number of offices for the medical staff, and living quarters for interns and residents, in addition to providing 88 private and semiprivate beds.

According to a hospital release, the five structures now comprising the main part of the hospital, totaling 516 beds, are between 60 and 92 years old.

Vincent G. Kling prepared the plans for the new building which will be built at a cost of $2,000,000.



RECENT COMPARATIVE HOSPITAL TESTS show tape method of mounting Electrocardiograph reports to be a marked improvement over staples, glue, cements or window folders. Long-life "Scotch" No. 800 Tape is almost invisible, eliminates the excess bulk, bending, smearing and loosening characteristics of other methods.

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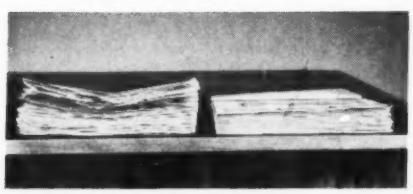

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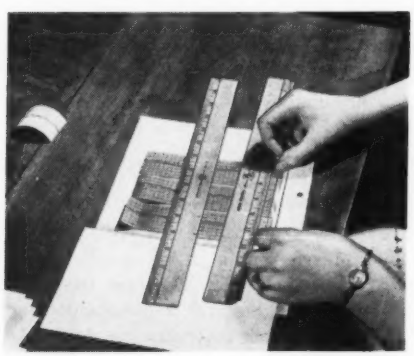

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3M

NEWS...

Florida Hospital Association Meeting

(*Continued From Page* 140)

accidents. "The best way to reduce insurance premiums is to prevent the insurance losses resulting from accidents and fires."

Steve McCrimmon, controller of Jackson Memorial Hospital, told of the cooperative work of a special committee from the Florida Association of Certified Public Accountants, the Florida Hospital Association, and the state auditor's office, in working on a hospital accounting manual and in developing uniform financial and statistical reporting forms for all hospitals in the state.

Executive Secretary J. F. Monahan reported that the state hospital association will soon have available for distribution to high school guidance counselors a loose-leaf manual giving full information on nursing and other professional school and training programs in Florida. This manual is one phase of a program designed to make available to high school students information on job and training opportunities in Florida hospitals.

Leo Brown, director of the department of public relations and assistant to the general manager of the American Medical Association, pointed out that there are just as many selfish, dishonest people in the medical profession as there are in law, education, hospital administration, and other professional groups.

"Let me tell you," said Mr. Brown, "that organized medicine is taking the necessary steps to eliminate, insofar as possible, abuses in the medical field by the minority." He mentioned the courageous action of the administrator of a hospital in a midwestern city in expelling a prominent staff surgeon for abusing his hospital privileges. He condemned the action of this expelled doctor in suing the hospital for libel and pointed out that this doctor's action is typical of the difficulties encountered by leaders in the medical and hospital professions in putting their houses in order.

Dr. Louis Block of the Division of Medical and Hospital Resources, U.S. Public Health Service, discussed accounting and statistics as an administrative tool. "Accounting information must tell the administrator what has happened as a measure against budgetary standards and must also give the administrator the figures needed for forward planning and better control of operations," Dr. Block said. He pointed out that accounting and statistics mean nothing unless keen administrative minds know how to use the figures.

Graham Miller, a practicing attorney in business law and a member of the faculty of the University of Miami, told the delegates that hospitals must help their attorneys bring about the best possible legal climate for the hospital. "The more people in your service area having a favorable attitude to the hospital," said Mr. Miller, "the more potentially sympathetic jurors you will have in the community in case your hospital is sued."

In discussing the hospital's public relations, Everett W. Jones listed the tools that hospital administrators and trustees must possess before they make any attempt to develop a public relations program.

(*Continued on Page* 198)

How Dictaphone Telecord saves time and money for New Mount Sinai

Staff members of New Mount Sinai Hospital, Toronto, Canada do a great deal of their paper work without leaving their posts, thanks to the Dictaphone Telecord telephone dictation system recently installed. To make their reports at any hour, day or night, *all they have to do is pick up a phone!*

Imagine the increase in efficiency such a system would mean to your hospital! Telecord's exclusive building-block flexibility allows expansion of the system without replacing any of the initial installation.

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(*Continued From Page* 196)

"One skeptical, uninformed trustee, one Jehovah-like, uncooperative, rude physician, one thoroughly ignorant employe, or an incompetent hospital administrator can destroy a large part of your public relations efforts," Mr. Jones asserted. He urged hospital administrators to find out what their immediate hospital neighbors, that is, the men and women owning businesses and homes in the hospital's neighborhood, think of the hospital. "You'd better be sure," said Mr. Jones, "that the folks in your neighborhood look upon your hospital and your team of hospital workers as good neighbors and that they consider your property to be a real asset to the immediate area."

One of the most impressive pieces of public relations that can be carried out is for the hospital administrator, every trustee, and every staff doctor to see to it that the hospital is organized to meet the new standards of the Joint Commission on Accreditation of Hospitals, Mr. Jones pointed out.

C. DeWitt Miller, owner and manager of the Wyoming Hotel in Orlando, and a former president of the board of directors of the Orange Memorial Hospital, was reelected president of Florida Blue Cross. H. A. Schroder was redesignated secretary and executive director. Samuel Gertner, executive director of Mount Sinai Hospital, Miami Beach, was named to the board of directors.

Mr. Miller announced that more than 400,000 people are now covered by Blue Cross in Florida. He made a plea to hospitals to renew their active support of Blue Cross principles, and to do everything in their power to help sell Blue Cross throughout the state.

Howard Cook of the American Hospital Association addressed the opening session of the women's auxiliary group and explained in detail the organizational procedure necessary for a successful auxiliary organization.

Everett W. Jones, vice president of The Modern Hospital Publishing Company, discussed the rôle of the auxiliary group as interpreters of hospitals at the Friday morning session. Mr. Jones pointed out that it is just as important for the auxiliary members to interpret the public's feeling about their hospitals to hospital authorities as it is to interpret the hospital to the public.

Women's auxiliaries can be of great assistance to hospitals in improving their financial status by helping hospital authorities convince local welfare officials to pay hospitals on a cost basis for indigent patients. "You must take on as one of your major jobs the recruitment of all types of hospital employes, with special emphasis on the recruitment of student nurses," Mr. Jones told the women.

John Wymer Jr., administrator of Good Samaritan Hospital, West Palm Beach, pointed out that completely frank interchanges of information and ideas, along with honest discussion of problems, are essential between hospital administrator and members of the women's auxiliary, in order to further successful interrelationships.

In addition to Mrs. Hare, the first president, other officers of the Women's Auxiliary of Florida Hospitals are: vice president, Mrs. Albert L. Franklin of Jacksonville and Mrs. Cyril B. Sutherland of Hollywood.

At the medical record librarians meeting Ilene Hall of Florida Sanitarium and Hospital in Orlando vacated the office of president in favor of President-Elect Jean Kelsey, record librarian at St. Joseph's Hospital in Tampa. Dorothy Waerner, librarian from Central Florida Baptist Hospital, Orlando, was named president-elect; Ann Sullivan of Brewster Hospital, Jacksonville, first vice president; Katherine Garthaus of St. Vincent's Hospital, Jacksonville, secretary, and Dorothy LeFevre of Morrell Memorial Hospital, Lakeland, treasurer.

Opens New Addition

LONGVIEW, WASH.—On the 10th anniversary of their taking over St. John's Hospital here, the Sisters of St. Joseph of Newark, N.J., opened a new addition to the hospital, raising its bed capacity to 125 beds. The new wing is now in service but remodeling on the old building continues.

The new wing accommodates new kitchen and storage facilities, employes' rooms and lockers. A thermal pack food system has been installed. In the medical section of the new wing is a room for mentally disturbed patients.

Sister M. Enda is administrator of the hospital.

You wouldn't buy a suit of clothes from a picture or a sales story. You *look* at the material . . . *feel* the quality . . .

This man is *feeling* the better value . . . *feeling* the better quality of a Day-Brite LUVEX® lighting fixture. There's no other way he can know how much extra strength, what greater ease of maintenance he'll get with LUVEX interlocked louvers—just one of many "more-for-your-money" LUVEX features.

HOW TO PROTECT YOURSELF

when you buy lighting fixtures

Buy lighting fixtures like you buy a suit of clothes. Look at them yourself . . . *feel* the value . . . *feel* the quality . . . *feel* the difference you can't always find in the sales stories.

Pictures and sales stories are excellent ways to bring competitive lines of fixtures to your attention.

But when you're ready to invest your money, *don't buy until you handle the fixtures yourself.* Don't buy until you're satisfied by your own inspection which fixture is *your* best buy.

We expect you to test the LUVEX (or any other Day-Brite fixture) in exactly that way. We know from experience your own judgment is the very best Day-Brite sales story we have.

LOOK AT THE LUVEX®. . . FEEL THE DIFFERENCE . . .

"DECIDEDLY BETTER"
DAY-BRITE
Lighting Fixtures

BEFORE YOU BUY!

Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Missouri
In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ontario

45

ABOUT PEOPLE

(*Continued From Page 90*)

of the American College of Hospital Administrators.

Dr. Raymond F. Smith, manager of the V.A. Hospital at Aspinwall, Pa., will also manage the V.A. Hospital in Pittsburgh, now nearing completion. Dr. Smith has been manager of the hospital at Aspinwall since 1946.

Walter V. Coburn has been named administrator of Ransom Memorial Hospital, Ottawa, Kan., succeeding **Richard Koss,** who recently became administrator of Savanna City Hospital, Savanna, Ill. Mr. Coburn was formerly administrative assistant at Lowell General Hospital, Lowell, Mass., where he served his residency after completion of a course in hospital administration at the University of Minnesota. He is a member of the Massachusetts Hospital Association, the Kansas Hospital Association, and the American Hospital Association.

Ralph W. Tarr is the new administrator of Grand Haven Municipal Hospital, Grand Haven, Mich. For the last two years he has been administrative assistant at Bronson Methodist Hospital, Kalamazoo, Mich., where he went upon completion of his administrative residency at Grace Hospital, Detroit. He is a graduate of the hospital administration program of the University of Chicago. **John C. Pratt,** assistant administrator of Flower Hospital, Toledo, Ohio, for the last three and a half years, has been named assistant superintendent at Bronson. After graduation from the course in hospital administration at the University of Minnesota, Mr. Pratt served his administrative residency at Harper Hospital, Detroit.

Roy C. House

Roy C. House has resigned as administrator of Gonzales Warm Springs Foundation, Gonzales, Tex., to accept a similar position at Marion General Hospital, Marion, Ind. Before being appointed administrator of the hospital at Gonzales, Mr. House had been assistant administrator of Samuel Merritt Hospital, Oakland, Calif. He received his master's degree in 1949 from Northwestern University and served his administrative residency at Methodist Hospital, Indianapolis.

John V. Connorton, administrator, lawyer and former professor, who has been executive director of the Greater New York Hospital Association since 1947, has been named deputy city administrator of New York, according to an announcement by **Dr. Luther Gulick,** new city administrator. Dr. Gulick stated that Mr. Connorton would deal especially with the institutions and the social agencies and would establish liaison with the mayor's office and with the voluntary social agencies of the city. Mr. Connorton is a member of the American Hospital Association, the American Institute of Management, and the Public Relations Society of America.

Philip J. Walsh, assistant administrator at Elizabeth General Hospital, Elizabeth, N.J., has been named administrator of Newcomb Hospital, Vineland, N.J., effective February 1.

Clifford G. Sawyer has resigned as director of Memorial Hospital of Bedford County, Everett, Pa., to accept a similar position at Babies Hospital-Coit Memorial, Newark, N.J. Mr. Sawyer received a master's degree in hospital administration from the University of

Chicago and has been associated with the Commonwealth Fund of New York City.

William P. Germain has resigned as administrator of Valley Children's Hospital, Fresno, Calif., to become administrator of Woodland Clinic Hospital, Woodland, Calif. Mr. Germain, a nominee of the American College of Hospital Administrators, was formerly assistant administrator of Children's Hospital, San Francisco.

Edward W. Gilgan, administrator of Ryburn Memorial Hospital, Ottawa, Ill., has resigned to become assistant administrator of Hurley Hospital, Flint, Mich. Mr. Gilgan, who received a master's degree from Northwestern University in 1949, is a member of the American College of Hospital Administrators.

Joseph F. McWilliams has been appointed administrator of City-County Hospital, McKinney, Tex. For the last four and a half years he held a similar position at South Plains Hospital-Clinic, Amherst, Tex.

Margaret Kinsey, superintendent of Joel Pomerene Memorial Hospital, Millersburg, Ohio, for the last five years, has resigned. She married recently and as Mrs. Elmer Mullet will make her home in Akron.

Robert Byrne, administrator of Woodmere State Hospital, Evansville, Ind., has been named administrator of Providence Memorial Hospital, El Paso, Tex.

Dr. G. A. W. Currie, director of the University of Colorado Medical Center, Denver, has resigned to accept the appointment as director of five units of John Sealy Hospitals, Galveston branch of the University of Texas Medical Center.

Walter B. Dillon is the new administrator of Annie M. Warner Hospital, Gettysburg, Pa., succeeding **Walter R. Doud,** who resigned. Before accepting his new appointment, Mr. Dillon was matériel management officer of the U.S. Public Health Service Hospital, Baltimore.

Sister Josephine Therese, formerly assistant administrator of St. Joseph Hospital, Wellington, Tex., has been named its administrator.


Leon J. Niemiec

Leon J. Niemiec has been appointed administrative assistant of St. Barnabas Hospital, New York City, succeeding **Miriam L. Neff.** Mr. Niemiec is a graduate of the course in hospital administration at Columbia University and served his administrative residency at Jackson Memorial Hospital, Miami, Fla.

Grover C. Bowles Jr., chief pharmacist at Strong Memorial Hospital, Rochester, N.Y., has been named to the central staff of the associate hospital administrators of the Memorial Hospital Association of Kentucky, Inc., Washington, D.C., as a consultant. He will be responsible for paramedical services, including primarily pharmacy, manufacturing and dispensing, and central sterile supply.

Department Heads

Lt. Col. Helen M. Abramoska, ANC, former chief of nursing service at U.S. Army Hospital, Fort Knox, Ky., has been appointed chief of the nursing branch at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex.

Miscellaneous

Josephine Handy, an anesthetist at Faulkner Hospital, Jamaica Plain,

The first truly elastic bandage that doesn't "die" in the dryer!

New TENSOR with Heat-Resistant live rubber threads can even be sterilized—and won't lose its stretch

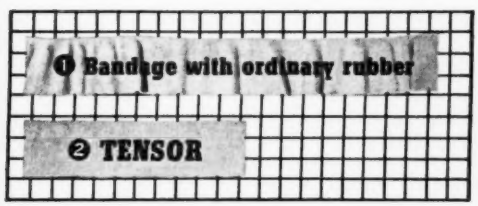
Here's the first truly elastic bandage that heat won't hurt—the first elastic bandage that *doesn't require special laundry care.*

New *Tensor* Elastic Bandages stand temperatures up to 280° F. with no appreciable loss of elasticity. The live rubber threads in *Tensor* are virtually unaffected by the high heat of commercial or hospital dryers. Even in the autoclave, *Tensor* keeps its stretch.

The result: *Tensor* Elastic Bandages last longer—and cost less to use. Even after many, many launderings, *Tensor* will still provide the uniform, steady, easy-to-control pressure that made it famous as the *first* truly elastic bandage.

Now available in hospital bulk put-up at no increase in cost. Why not specify new *Tensor* next time you stock your supply room.

COMPARE THESE ELASTIC BANDAGES



❶ One-foot length of bandage made with ordinary rubber is stretched after high temperature drying—and stays stretched. Its elasticity "died" in the dryer.

❷ But one-foot length of heat-resistant Tensor snaps back to its original length, even after prolonged exposure to near scorching heat of commercial dryer.

New TENSOR® ELASTIC BANDAGE

Woven with Heat-Resistant live rubber threads

BAUER & BLACK

Division of The Kendall Company
309 West Jackson Blvd., Chicago 6, Ill.

Mass., has been appointed assistant to the executive director of the American Association of Nurse Anesthetists, whose offices are in Chicago.

E. Burns Geiger, for the last six years director of the V.A. pharmacy service, has resigned and will be succeeded by **Vernon O. Trygstad,** his assistant for the last two years.

Maurice H. Matzkin, first deputy commissioner of hospitals, New York City, has been named acting commissioner to fill the vacancy created by the resignation of **Dr. Marcus D. Kogel,** which became effective December 31. Mr. Matzkin has served as deputy commissioner for the last eight years.

Trustees

Frank F. Selfridge, who has been president of the board of trustees of Highland Park Hospital, Highland Park, Ill., since 1945, has resigned. Succeeding him is **Edward A. Ravenscroft.**

Deaths

Neal R. Johnson, purchasing agent for Johns Hopkins Hospital, Baltimore, for 30 years, died in December. Mr. Johnson was one of the first members of the A.H.A.'s committee on purchasing, simplification and standardization and had served as its chairman. Believing that a formal educational training program for purchasing agents should be provided, he was largely responsible for the establishment of the institutional management courses now being given in Columbia University's School of General Studies.

Mary Reid, superintendent of Presbyterian Hospital of the Columbia-Presbyterian Medical Center, New York City, until her retirement in 1950, died in December.

Dr. Scott Johnson, medical director of Lincoln and Knickerbocker hospitals, New York City, and associate professor of medicine at Cornell University, died in December.

Capt. Robert Eustis Hoyt, retired navy medical officer, died in December. He was the first commanding officer of the U.S. Naval Hospital, Bethesda, Md.

William H. P. Blandy, retired admiral of the navy, who for the last two years had been president of the Health Information Foundation, a research organization supported by the pharmaceutical industry in New York City, died January 12.

Dr. Ole C. Nelson, 72, medical superintendent of Cook County Hospital, Chicago, from 1943 until last July when he retired, died in January. Dr. Nelson had been a member of the hospital's staff for 42 years.

Illinois Governor Names Hospital Licensing Board

SPRINGFIELD, ILL. — Seven appointees to a newly created hospital licensing board were named here last month by Gov. William E. Stratton.

Set up under a new law, the board will advise the state health department and approve licensing requirements for all hospitals except those federally owned or state operated.

Named to the board are: Dr. Theodore R. Van Dellen, Northwestern University School of Medicine; Msgr. John W. Barrett, diocesan director of Catholic hospitals, Chicago; Elmer E. Abrahamson, secretary of the board of Norwegian-American Hospital, Chicago; Dr. Harlan English, Danville; George K. Hendrix, Springfield; Dr. George H. Van Dusen, East St. Louis, and I. R. Abbott, Decatur.

Here's

the

BIG TRUTH*

about

boilers...

***The only safe way to select boilers is on nominal capacity to operate at "cruising speed"...**

KEWANEE

reserve plus rating

guarantees dependability, higher efficiency, lower costs, longer life—because it means "cruising speed" operation.

There's a lot of confusion in sizing boilers today because rating methods have not been brought into the open with a clear-cut definition. That's all changed with Kewanee Reserve Plus Rating. Here for the first time these truths are stated: Only nominal-rated boilers with built-in reserve *safely provide* efficiency—low maintenance—dependability—longer life. Only nominal-rated boilers *safely provide* for fluctuating loads—emergencies—expansion.

So when you consider "bidding data" be sure you compare like examples . . . know whether ratings are based on maximum capacity or nominal capacity.

Follow the Kewanee Reserve Plus Rating Plan which is based on the commercial code of the Steel Boiler Institute. Kewanee Reserve Plus certifies 50% or more extra power for pick-up and additional capacity. Kewanee gives you complete data and dimensions, so you can realistically consider sizing requirements.

You can count on* KEWANEE *engineering

KEWANEE-ROSS CORPORATION • KEWANEE, ILLINOIS
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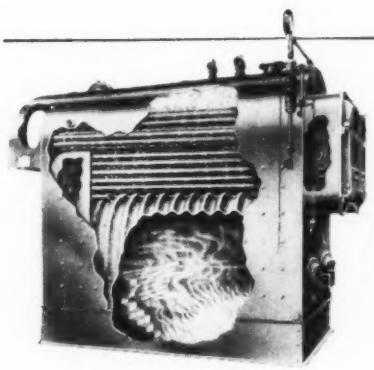
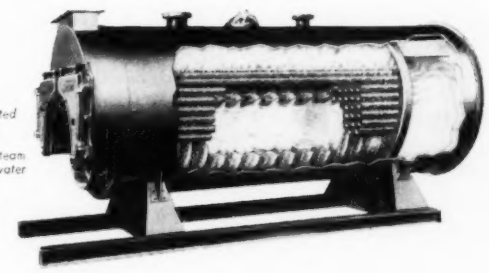
Serving home and industry • American-Standard • American Blower
Church Seats & Wall Tile • Detroit Controls • Kewanee Boilers
Ross Exchangers • Sunbeam Air Conditioners

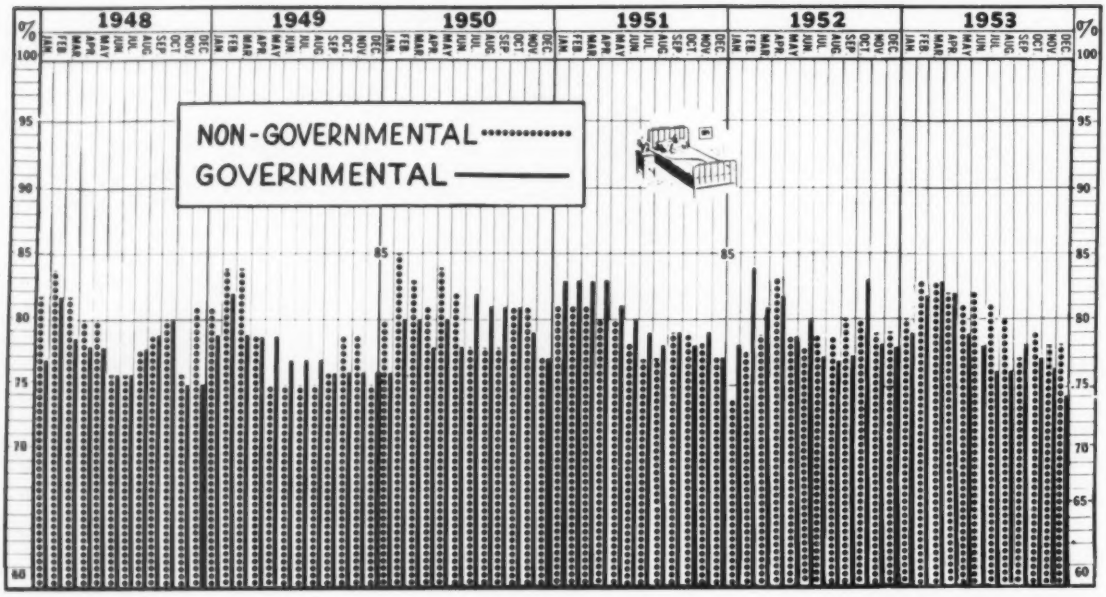


Kewanee type "C" boiler
with exclusive corrugated crown sheet. 16 sizes for oil, gas or stoker 3650—42500 sq. ft. steam 5840—68000 sq. ft. water



M-800 series boiler
Here is rugged "M-800" Series Scotch Boiler constructed in 13 sizes for high pressure steam 39 to 304 horse power and low pressure 15 lb. steam or 30 lb. water

1954 Begins With Construction Total of $19,583,490



Government hospitals, in their reports to the Occupancy Chart for the month of December, indicate an average daily occupancy of 74.4 per cent. This represents a 13.1 per cent decline from the figure reported a year ago.

Nongovernment hospitals have reported occupancy of 77.9 per cent of capacity for December—a 10.2 per cent rise over December 1952.

Hospital construction for the current period, December 28 to January 11, aggregated $19,583,490. Twenty-two projects were reported during the latest period. Six new hospitals reported will cost $2,760,000; 15 additions will be built for $14,486,000, and the one alteration will cost $275,000.

After 18 Months of Continuous Use...

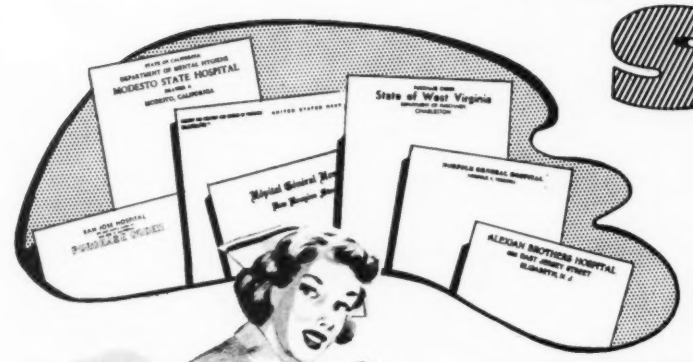
here is what a leading hospital says about

Sani Philm*

"Electronically Welded" Plastic

- **MATTRESS COVERS**
- **PILLOW COVERS**
- **DRAW SHEETS**

Even the Rustproof Zippers are Electronically Welded — no sewing or thread to tear.

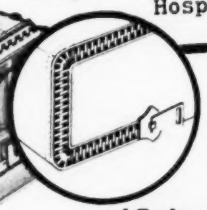


"...We have found no need to replace any of them and I certainly hope that, except for rare damage, they will last even longer than we had originally expected. We are quite satisfied with the covers and think that they have greatly reduced the cost of maintenance and repair of mattresses and pillows, besides making cleaning of such units much simpler."

—Howard W. Baker, M.D.
Administrator
Temple University Hospital

PHILMONT
Sani Philm*
Plastic
BEDDING PROTECTORS

Guaranteed by Good Housekeeping



—and Today, after 37 Months...No Complaints!!

Purchase Orders . . . Letters of Praise . . . Acceptance by U.S. Government Agencies and the nation's foremost Hospitals . . . attest to the outstanding performance of SANI-PHILM Bedding Protectors.

SAVE MONEY! Lengthens life of Mattresses, Pillows!

SAVE TIME! SANI-PHILM Protectors fit wrinkle-free over beds in just a few seconds. Cuts change time...increases efficiency of Nurses.

SAVE LAUNDERING! Keeps your hospital bedding clean, fresh, new . . . no need for constant sterilization.

ADDED PATIENT COMFORT! Wrinkle-free, odorless . . . no rustling sound when patient shifts position.

*None GENUINE without this Registered Trade Mark.

Rigidly laboratory tested for resistance to steam, bacteria, fungi, stains, odors, burning, cracking, allergic qualities. Complete protection against dust and dirt, perspiration and normal body discharges. Boilable, odorless, noiseless, waterproof . . . (even at the seams!) ELECTRONICALLY WELDED, RUSTPROOF ZIPPERS! Constructed in accordance with U.S. Government Specifications in .006 and .008 thickness—not less! Philmont manufactures more SANI-PHILM Bedding Protectors for the U.S. Government than all others combined!

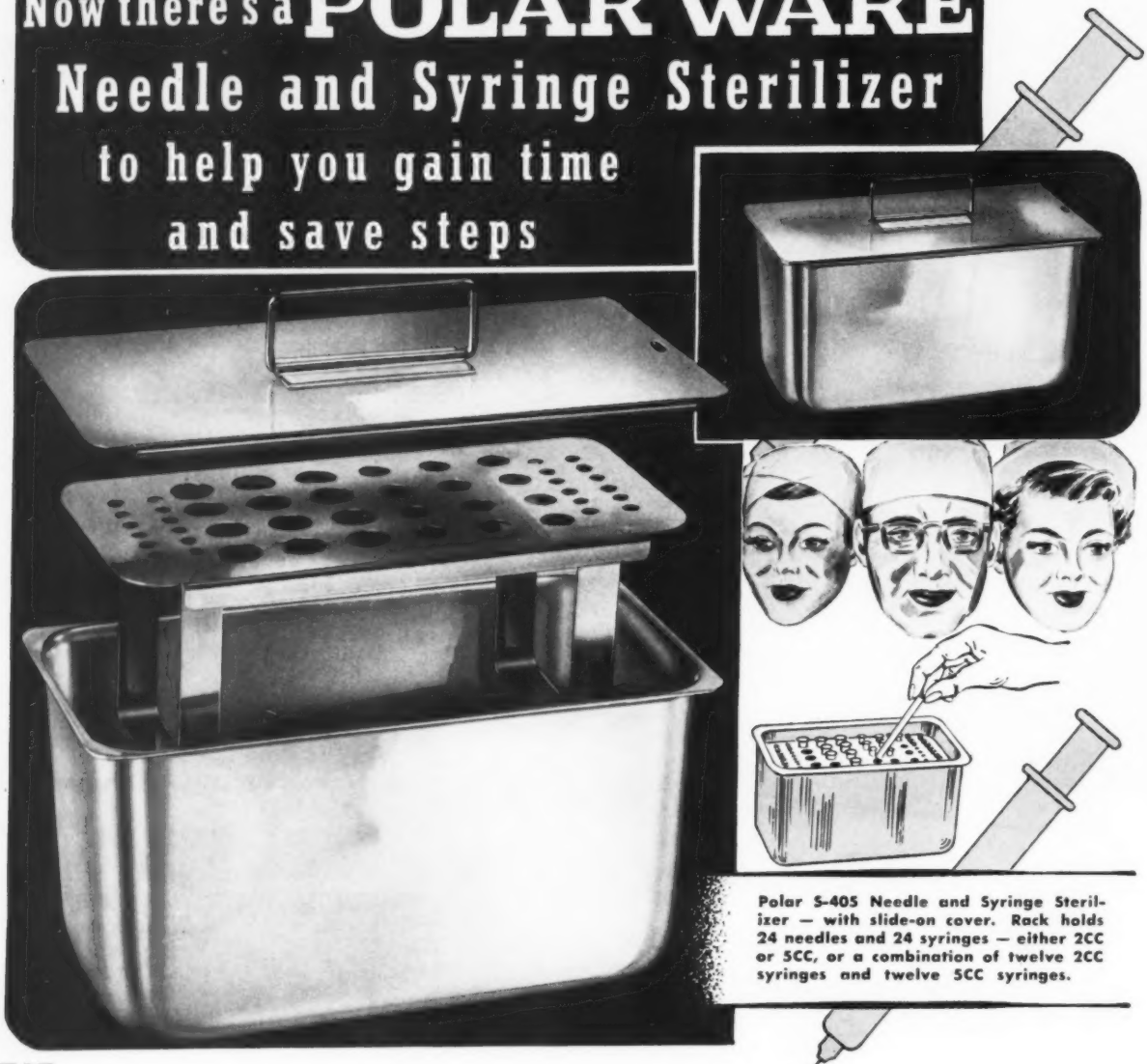
Tremendously expanded production facilities enable us to pass on huge savings of 50%, as follows:

#206—.006	Size of Mattress 36x78x6	**$36** doz.
#308—.008	Size of Mattress 36x78x6	**$45** doz.
#1004—.004	Pillow Covers 27x21	**$ 6** doz.

Terms: net 30 days F.O.B. Englewood, N.J. Prices for other sizes upon request.

PHILMONT MANUFACTURING CO.
HOSPITAL DIVISION, ENGLEWOOD, N. J.

Now there's a POLAR WARE Needle and Syringe Sterilizer to help you gain time and save steps



Polar S-405 Needle and Syringe Sterilizer — with slide-on cover. Rack holds 24 needles and 24 syringes — either 2CC or 5CC, or a combination of twelve 2CC syringes and twelve 5CC syringes.

WHEN you can assemble—and carry—24 syringes and needles for hypodermic injections in one handy, compact sterile box, think of the steps that you save, the time that you gain wherever you work . . . in ward rooms, central supply, surgery or outpatient clinic. Even more, there is no need to wrap syringes or needles for sterilizing — for this Polar sterilizer of heavy gauge stainless steel is designed for autoclaving. It provides individual syringes and needles ready for instant use without breaking the sterile field. And because it's Polar Ware, you know it's *right*. Pans, covers and racks have well-rounded corners for safe and easy cleaning. Pan bottom is paneled to permit stacking. Time and again this Polar sterilizer will repay its small cost over the years that it will serve you.

Ask the supply house men who call about this functional, practical new addition to the Polar line. You'll find the best of them carry Polar Ware.

Polar Ware Co. *4300 LAKE SHORE ROAD SHEBOYGAN, WISCONSIN

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POSITIONS WANTED

ANESTHETIST—Registered nurse; free lance anesthetist desires position in small 50-75 bed hospital; experienced all types of anesthetics; southeast preferred; 24-hour calls taken. Reply, MW 25, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

HOUSEKEEPER—Executive; 2 years experience, assistant housekeeper, 350-bed hospital; wants more responsibility; B.S. Degree in Home Economics; good background in personnel; midwest. MW 27, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERINTENDENT—Registered nurse; 10 years experience; excellent references; will consider Supervisor position with good salary. MW 26, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

The Medical Bureau

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PALMOLIVE BUILDING CHICAGO

ADMINISTRATOR—Medical; four years, assistant director, large teaching hospital; six years, director, voluntary general hospital, 350 beds; FACHA.

ADMINISTRATOR—B.S., Education, Master's Business Administration; five years, assistant director, teaching hospital; seven years, administrator, 400-bed general hospital; FACHA.

ADMINISTRATOR—Master's, Hospital Administration; two years, assistant administrator, 300-bed hospital; four years, associate director, university department of hospital administration.

ADMINISTRATOR—Graduate nurse; Master's, Hospital Administration; four years, administrator, 65-bed hospital.

COMPTROLLER—Bachelor's Degree in Business Administration; six years comptroller, 250-bed hospital.

PATHOLOGIST—Diplomate, Pathologic Anatomy and Clinical Pathology; three years, pathologist, teaching hospital and on faculty medical school; five years, director of pathology, 250-bed hospital.

PERSONNEL DIRECTOR—A.B.; graduate training, personnel management; six years, personnel director, large general hospital.

RADIOLOGIST—Diplomate; Fellow, American College of Radiology; seven years, director, radiology, 300-bed hospital; now associated with radiological group; prefers directorship, hospital department.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Day, Director

332 Bulkley Building

Cleveland, Ohio

ADMINISTRATOR—Or business manager; 3 years assistant administrator, 300-bed Maryland hospital; 6 years present position, 120-bed eastern hospital.

INTERSTATE—*Continued*

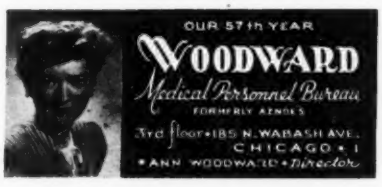
ASSISTANT ADMINISTRATOR—Age 36; graduate, Columbia University; 2 years administrative resident and assistant, well-known western hospital.

BUSINESS MANAGER—B.S. Degree, University of Chicago; 5 years office and credit manager, 200-bed Illinois hospital; at present, administrator, 75-bed Minnesota hospital; desires change.

COMPTROLLER—C.P.A. rating; 2 years auditor, large firm, Michigan; 6 years office manager; 2 years comptroller, large eastern hospital.

EXECUTIVE HOUSEKEEPER—B.A. Degree, eastern college; 4 years, assistant housekeeper, 400-bed midwestern hospital; present position 5 years, 250-bed Pennsylvania hospital.

NURSE SUPERINTENDENT—B.S. Degree, Wooster College; 5 years experience, director, nursing service; 7 years administrator, 85-bed hospital, midwest; new building erected, 1952; well recommended.



ADMINISTRATOR—Lay; well-seasoned and experienced; experience includes several years, director, general hospital, 150 beds; 6 years, director, voluntary general hospital, 300 beds; middle 30's; cultured gentleman; member, ACHA.

ADMINISTRATOR—Medical; assistant director, university hospital, 4 years; 6 years, director, important medical center; FACHA.

ADMINISTRATOR—Graduate nurse; 7 years, administrator, voluntary general hospital, 500 beds; outstanding woman; FACHA.

ANESTHESIOLOGIST—Diplomate; trained university hospital; several years, successful private practice, anesthesiology; 3 years, anesthesiologist, USAMC; 8 years, director, anesthesiology, general hospital, 350 beds.

DOCTOR COUPLE—Wife, anesthetist; husband finishing 5 years surgical residency; both trained university hospitals; early 30's; prefer southeast, southwest, Rocky Mountain area; $8-$10,000 each; available July.

CHEMIST-BIOCHEMIST—B.S., M.A., Ph.D.; age 28; seeks teaching; research; 18 months, senior chemist, pharmaceutical company; $6500.

EDUCATIONAL DIRECTOR—M.S., Nursing Education; capable organizer; 10 years experience, large teaching hospitals; prefer southeast; middle 40's.

OPERATING ROOM SUPERVISOR—3 years, operating room nurse, large teaching hospital; 5 years, operating room nurse, USANC; 3 years, operating room supervisor, medical research center; can also supervise obstetrics.

(Continued on page 210)

WOODWARD—*Continued*

PATHOLOGIST—M.S., Medicine; Diplomate, pathologic anatomy, clinical pathology; 12 years, director, departments, pathology, several university hospitals including 6 years, professor, forensic pathology; prefers directorship, pathology, large hospital or several smaller institutions; outstanding man; middle 40's.

PATHOLOGIST—33; Certified, pathologic anatomy; eligible, clinical pathology; 2 years, chief pathologist, army hospital; 1 year, assistant pathologist, pathologic institute; just being separated military service.

RADIOLOGIST—34; Diplomate; trained teaching hospitals; 1 year, associate radiologist, Henry Ford Hospital; finishing 2-year army tour, radiology.

POSITIONS OPEN

ADMINISTRATIVE SUPERVISOR—11-7 shift; 40-hour week; 332-bed general hospital with school of nursing; desire Bachelor of Science Degree; experience as administrative supervisor or head nurse essential; liberal personnel policies; living accommodations available; salary commensurate with qualifications; immediate opening. Apply, Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

ANESTHETIST—Nurse; starting salary $325 plus complete maintenance and $10 each night on call; on call duty four to six nights monthly; eight nurse anesthetists on staff; three weeks' vacation and twelve sick leave days per year; automatic annual pay increase and bonus. Apply, Mrs. F. Stowe Burwell, Charlotte Memorial Hospital, Charlotte, North Carolina.

ANESTHETIST Registered nurse, with two or more years' experience, for 200-bed hospital on Florida's Gulf Coast; medical anesthesiologist in charge of department; good s 'ary, living quarters; yearly vacation and sick leave. Write to MO 67, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write, Robert M. Jones, Assistant Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.

ANESTHETIST—Nurse; modern 115-bed, acute general hospital; department in charge of certified medical anesthetist; salary open. For particulars, write Director, Department of Anesthesiology, Mount Sinai Hospital, Hartford, Connecticut.

ANESTHETIST—Nurse; 5 days; salary open; 65-bed specialized hospital. Newark Eye and Ear Infirmary, 77 Central Avenue, Newark, New Jersey.

ANESTHETIST—Nurse; 45-bed general hospital; new surgery, modern anesthesia equipment; no obstetrics; very attractive salary; unusual opportunity to increase present earning power; position open April 1, 1954. Contact Administrator, Victory Memorial Hospital, Stanley, Wisconsin.

ANESTHETIST—Nurse; for new 50-bed, fully approved hospital; good working conditions, salary $450, and other benefits. Apply, Delnor Hospital, St. Charles, Illinois.

classified advertising

POSITIONS OPEN

ANESTHETIST—Approved small hospital in Oklahoma; lovely nurses home; salary $350 per month plus full maintenance; paid vacation and sick leave. Apply, Medical Director, Community Hospital, Elk City, Oklahoma.

ANESTHETIST—Nurse; 135-bed general hospital; ACS and AMA approved; 3 weeks paid vacation, 2 weeks sick leave, 6 paid holidays; social security. In replying, enclose photograph, state age and experience; mail to Attention Administrator, Clearfield Hospital, Clearfield, Pennsylvania.

ANESTHETIST—Nurse; for 100-bed cancer hospital; active major surgical service; congenial working conditions; excellent equipment; very little call; 40-hour week; salary $448 to $572. Apply, Medical Director, Ellis Fischel State Cancer Hospital, Columbia, Missouri.

ANESTHETISTS—Immediate openings available: A.A.N.A. members, two nurse anesthetists needed; obstetric anesthesia in a very active department with 350 to 400 deliveries monthly; eight hour rotating shifts; $350 a month beginning salary with room and laundry; 50 per cent of anesthesia fee per case for second call; social security; very pleasant working conditions. Apply, Administrator, Good Samaritan Hospital, Dayton, Ohio.

ANESTHETIST—Nurse; starting salary $450 per month; 90-bed hospital; on call every other week end. Contact Administrator, Harrison Memorial Hospital, Bremerton, Washington.

ANESTHETISTS—Nurse; for 150-bed general hospital; four nurses, full-time M.D., all agents and techniques; one month's vacation; two and one-half hour from Boston and New York. Write, G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick, Canada.

DIETITIAN—Assistant; 340-bed general hospital, school of nursing, western Maryland; salary $3000-$4200 plus maintenance. Apply, John Schaffer, Administrator, Washington County Hospital, Hagerstown, Maryland.

DIETITIAN—Qualified dietitians on present staff enable choice of theapeutic or administrative duties for newcomer; opportunity to round out your experience; 242 beds, recently expanded; near Chicago. Methodist Hospital, Gary, Indiana.

(Continued on page 212)

DIETITIANS—Department of Health, General Hospital (475 beds), St. John's, Newfoundland, invites applications for the following posts: (1) A Chief dietitian to take charge of the dietary department; salary $3000 per annum on the scale of $3000-100-3300; this post is a civil service appointment and is pensionable (non-contributory); 5-day working week, 4 weeks annual leave on full pay plus statutory holidays, generous sick leave, etc. (2) Dietitians to work under supervision of the chief dietitian; salary $2800 per annum on the scale $2800-100-3000; pensionable posts (non-contributory); 4 weeks annual leave on full pay, 8-hour day, straight shifts, 44-hour week, with all statutory holidays, generous sick leave, etc.
Traveling expenses to St. John's for candidates appointed will be paid by the Department of Health. Applications stating qualifications, experience, etc., with full details, together with two names for reference should be sent immediately to: E. Wilson, M.D., Superintendent, General Hospital, St. John's, Newfoundland.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIRECTOR—Educational; for school of nursing; 200 students enrolled; 700-bed hospital. Apply, Superintendent of Nurses, Royal Alexandra Hospital, Edmonton, Alberta, Canada.

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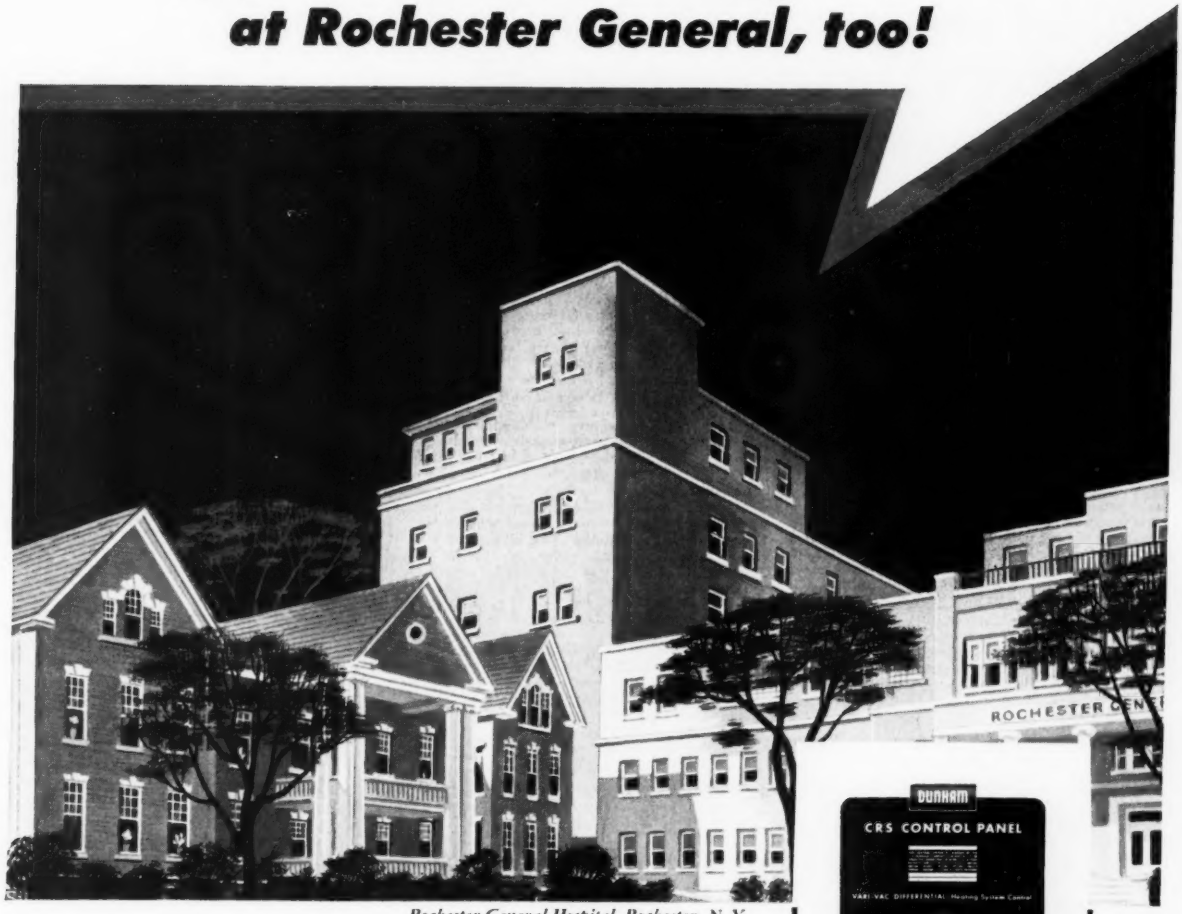

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POSITIONS OPEN

INSTRUCTOR—Clinical; registered nurse for teaching theory and practical aspects of nursing arts and science within clinical areas of hospital; paid benefits, excellent working conditions, living accommodations available. Write Personnel Office, The Jewish Hospital, Cincinnati 29, Ohio.

INSTRUCTOR—Clinical, medical-surgical; 155-bed general hospital; 75-bed addition in near future; salary $260 per month with complete maintenance; good personnel policies; 44-hour week. Apply, Director of Nurses, Chesapeake and Ohio Hospital, Clifton Forge, Virginia.

INSTRUCTOR—Medical clinical; in 225-bed hospital; 130 students in the school of nursing; assume full responsibility for classroom and ward teaching; 40-hour week, 4 weeks paid vacation, 7 paid holidays, sick leave accumulative to 30 days; salary open. Apply, Tacoma General Hospital School of Nursing, 314 South K Street, Tacoma, Washington.

INSTRUCTOR—Science; approved school of nursing has excellent opportunity for qualified science instructor; fine, modern equipment; living accommodations available; salary open; pension plan; travel arrangements for interview. Apply to Personnel Director, The Christ Hospital, 2139 Auburn Avenue, Cincinnati, Ohio.

INSTRUCTOR—Clinical, obstetrical nursing; degree and experience required; 240-bed hospital, 95 students in school; 40-hour week; 4 weeks paid vacation; salary open. Apply, Director of Nursing, Luther Hospital, Eau Claire, Wisconsin.

INSTRUCTORS—Clinical; in the medical and surgical areas; 332-bed hospital located in an attractive residential section; student body of 160; Degree in Nursing Education and some teaching experience preferred; salary range for 40-hour week $320-$430; beginning salary commensurate with experience and preparation; liberal personnel policies; living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTORS—Openings for clinical instructors in medicine, surgery, obstetrics, and psychiatry; nationally accredited school of nursing, St. Louis City Hospital; good personnel policies; municipal civil service; 40-hour work week; social security; liberal vacation and sick leave; salary $298.90-$330.90; qualifications desired: B.S. in Nursing and experience in clinical field. Apply: Director, School of Nursing, 1515 Lafayette Avenue, St. Louis 4, Missouri.

INSTRUCTORS—Nursing arts instructor and Clinical instructor; 225-bed hospital; 90 students, 3-year course; 30 students admitted each year; insurance plan; social security; liberal vacation; degree required; salary arrangements open for negotiation; travel allowance. Apply, Director Nursing Education, or Administrator, Bismarck Hospital, Bismarck, North Dakota.

LIBRARIAN—Medical record, registered; to head department of 635-bed voluntary non-profit J.C.A.H. approved teaching hospital; approximately 25,000 discharges annually, plus 45,000 visits outpatient department; medical staff all Board certified; department has 26 employees and consequently requires a person with exceptional organizational and administrative ability; active medical record and tissue committee; standard nomenclature and unit numbering system; salary open but commensurate with size of department and the experience and ability of applicant. Apply, Director, Harper Hospital, Detroit 1, Michigan.

LIBRARIAN—Attractive position for person interested in light but responsible work in medical library of psychiatric hospital, Philadelphia; suitable for retiring librarians; 5-day week; salary $2400. MO 69, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS—Psychiatric supervisor, Clinical instructor and Administrative supervisor; 483-bed general hospital with school of nursing nationally accredited; salary open depending upon experience; 40-hour week. Write to Director of Nursing, Butterworth Hospital, Grand Rapids, Michigan.

NURSES—General duty; 150-bed hospital; 40-hour week; paid vacations, holidays and sick leave; cash salary $220 month. St. Mary's Hospital, West Palm Beach, Florida.

(Continued on page 214)

classified advertising

POSITIONS OPEN

NURSES—Assistant head nurses; registered: due to expanding facilities, openings available in all areas—surgical, medical, obstetrics, etc.; living accommodations available; paid benefits. Write Personnel Office, Jewish Hospital, Cincinnati 29, Ohio.

NURSES—General duty, registered, urgently needed for new 30-bed wing; start at $225, night shifts $235; $5 increase every 6 months; 3 weeks paid vacations; 14 days sick leave; 6 holidays; living in optional. Write, Director of Nurses, Franklin Hospital, Franklin, Pennsylvania.

NURSES—General duty, for all services; also Director of nursing service, Evening supervisor, Clinical supervisors, medical, surgical and obstetric; Head nurses and Assistant head nurses, medical, surgical and orthopedic divisions; liberal personnel policies and salary scales. Write or apply, Director of Nursing, Hospital of St. Anthony de Padua, School of Nursing, 2875 West 19th Street, Chicago 23, Illinois.

NURSES—General duty nurses wanted for summer positions, June 1 to October 31; spend your summer in Bar Harbor and see beautiful Acadia National Park; permanent nurses also needed. Write for full details: Mt. Desert Island Hospital, Bar Harbor, Maine.

NURSES—General duty; with mature judgment, 30-45 years of age; several needed for school for cerebral palsied children, located 15 miles north of Baltimore; 8-hour day, 6-day week, rotating shifts; salary $250 per month with regular increases for satisfactory service. For personal interview, write or phone: Miss Verna Mae Brandt, R.N., Supervisor of Nurses, Children's Rehabilitation Institute, Cockeysville, Maryland. Phone: Cockeysville 230.

NURSES—General staff; for 350-bed general hospital; no obstetrics; center city location; 40-hour week; 3 weeks vacation; $220 monthly base gross salary; $20 monthly increment for 3-11 and 11-7 tour of not less than one month; 50% discount on tuition rates for University of Pennsylvania matriculation. University of Pennsylvania Graduate Hospital, 1818 Lombard Street, Phliadelphia 46, Pennsylvania.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains; 8-hour day, 6-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply, Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Graduate; staff and supervisory positions for all services; new 200-bed general hospital; ideal working conditions, liberal personnel policies; salary $240 up; differential for evening and night duty; 40-hour week; limited number of rooms for nurses available. Apply, Director of Nursing, St. Charles Hospital, Wheeling and Navarre, Toledo, Ohio.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—General staff; for new 32-bed hospital opened 2 years; liberal salary; excellent working conditions. Apply, Administrator, Wells Municipal Hospital, Wells, Minnesota.

NURSES—Staff and operating room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary $250 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

(Continued on page 215)

classified advertising

POSITIONS OPEN

PHYSICAL THERAPIST — Registered; well equipped department in 340-bed general hospital; 75 miles from Baltimore and Washington; salary $3600-$4500. Apply, MO 70, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR AND INSTRUCTOR—Operating room supervisor and clinical instructor for modern 250-bed hospital and school of nursing, 70 miles from New York City; fully approved; forty-hour week; four weeks paid vacation; sick time; hospital care; complete maintenance at $45 per month; salary $305 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

SUPERVISOR—Registered nurse; degree not necessary; responsibility of medical and surgical patient areas; supervision of graduate nurses and auxiliary personnel; salary dependent upon experience and ability; living accommodations available; 40-hour week, paid benefits. Write Personnel Office, The Jewish Hospital, Cincinnati 29, Ohio.

SUPERVISOR—Medical clinical; 215-bed general hospital; 100 students; 40-hour week; preparation for clinical field, a B.S. Degree or working toward a degree; salary open; liberal personnel policies. Apply, Director of Nurses, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISOR—Registered nurse for supervisor of 28-bed hospital; salary open. If interested, contact Curtis Clinic Hospital, Mansfield, Louisiana.

SUPERVISOR—Teaching; immediate opening in medical and surgical nursing; degree required; attractive, new 220-bed hospital; salary $4200-4800; four weeks vacation. Inquire: Director of Nursing, Bradford Hospital, Bradford, Pennsylvania.

SUPERVISORS—Operating room supervisor and Assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

TECHNICIAN—Permanent laboratory technician wanted beginning May 1; also temporary technician June 15 to October 31. Write for full details to Mt. Desert Island Hospital, Bar Harbor, Maine.

TECHNICIAN—Laboratory; $250 per month; 5½ days per week; 2 weeks vacation wtih pay after one year's service; pleasant working conditions. Apply or write, Doctors Hospital, 111 West 4th Street, Bethlehem, Pennsylvania.

TECHNICIAN — Laboratory; 67-bed hospital; salary open. Apply, Superintendent, General Hospital, Portage la Prairie, Manitoba, Canada.

TECHNICIANS—For general laboratory work; in 338-bed hospital; salary dependent on qualifications. Apply: Pathologist, York Hospital, York, Pennsylvania.

(Continued on page 216)

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS—(a) Director, teaching hospitals, university medical school; slight preference for medical administrator. (b) Medical; voluntary general hospital, 400 beds, affiliated medical school; remarkably fine Board; staff principally Board men; university center; east. (c) General hospital, 375 beds; large outpatient department; medical staff well organized, departmentalized; graduate training programs; resort city; south. (d) Associate medical director; 700-bed teaching hospital; $15,000. (e) Director, voluntary general hospital, 275 beds; campaign recently completed for expansion program; city, 100,000, metropolitan area of East. (f) Small general hospital; building program; college town, south. (g) Voluntary general hospital, 150 beds; resort town, midwest. (h) Executive director; state hospital association. (i) General hospital; fairly large size; currently under construction; competent organizer required; Pacific coast; minimum, $12,000. (j) Assistant director; new hospital, 500 beds, under construction, to replace present hospital; 250 beds; university town. MH2-1

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ADMINISTRATORS — NURSES. (a) Small general hospital currently under construction; completion, June; $7-$8000. (b) New community general hospital; 45 beds; New England. (c) Assistant; 400-bed general hospital, large city, midwest. MH2-2

ANESTHETISTS—(a) Director, school of anesthesia; degree, considerable experience, minimum one year in nursing education (anesthesia), teaching ability desired; 500-bed general hospital; $7000. (b) Association, group medical anesthesiologists; Pacific coast. (c) Association, five-man group; own hospital; small town, on Gulf of Mexico; $500. (d) Two for operating room only; large general hospital; hour's ride from New York City; $400-$500. (e) Association, 10-man group; own hospital; college town, California; $450-$550. (f) Modern general hospital, 100 beds; college town, midwest; $6000, maintenance. MH2-3

DIETITIANS—(a) Chief dietitian; large teaching hospital; Pacific coast. (b) Food service director and special instructor in home economics; duties include management dining room serving 125, cafeteria, snack bar; liberal arts college; midwest. (c) Chief dietitian; voluntary general hospital serving 800 meals daily; Connecticut; $5000. (d) Assistant dietitian; new hospital; Central America. (e) Assistant dietitian; 200-bed general hospital; resort town, 60,000, Texas. (f) Nutrition advisor; industrial company; university center, east. MH2-4

DIRECTORS OF NURSES — (a) Teaching hospital, 700 beds; one of country's leading schools of nursing; 300 students; facilities of the best; new nurses' residence; east. (b) Voluntary general hospital; 265 beds; 90 students; one particularly interested in students required; California. (c) General 350-bed hospital affiliated with diagnostic clinic; staff of 25 specialists; college town near several large cities. (d) Voluntary general hospital, 350 beds; 165 students; university affiliation; two associate directors; Master's required; university medical center. (e) General 250-bed hospital; collegiate program; college town, midwest; $6000-$7000, maintenance. (f) Nursing service only; general 250-bed hospital, succeed director retiring after 20 years; attractive town, California. (g) Associate director, nursing service; large teaching hospital; medical center, east. (h) Nursing service; new hospital, 125 beds; college town south. MH2-5

EXECUTIVE HOUSEKEEPER—Large teaching hospital; east; $4500. MH2-6

EXECUTIVE PERSONNEL — (a) Controller experienced in hospital accounting and business office management; qualified direct staff of 35; large teaching hospital; $6-$10,000. (b) Personnel director; 600-bed general hospital; thousand employees; university center, east; $8000. (c) Purchasing agent; university group; large city medical center, east. (d) Public relations director; 400-bed hospital; midwest. (e) Chief engineer; new hospital, 500 beds, under construction, to replace present hospital, 250 beds; university town. MH2-7

FACULTY POSTS—(a) Coordinator, three-hospital nursing education program; collegiate affiliations; 250 students; university city. (b) Chairman, university nursing education department currently being instituted; qualified faculty in sciences, humanities, general education will contribute to program; up to $9000. (c) Educational director; large teaching hospital; university medical center; south. (d) Educational director; duties include serving as assistant director of nursing; California. (e) Instructor in health; duties: supervising health program, counseling, teaching hygiene, public health; 350-bed general hospital; residential and college town, vicinity New York City. (f) Assistant nursing arts instructor and coordinating instructor in medical-surgical nursing; department of nursing; state college; $4200-$5000; midwest. MH2-8

MALE NURSES—(a) Psychiatric instructor; large teaching hospital; midwest. (b) Anesthetist; group, medical anesthesiologists; California. (c) Two staff; small hospital; outside United States. MH2-12

MEDICAL RECORD LIBRARIANS — (a) Chief, medical record section, new medical center; competent organizer required; $5000-

(Continued on page 217)

classified advertising

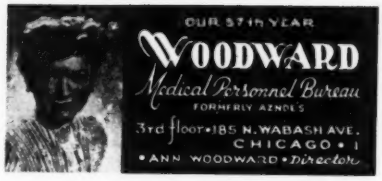
POSITIONS OPEN

MEDICAL BUREAU—*Continued*

$6500. (b) Chief and assistant; new hospital, fairly large size; California. (c) Assistant; large teaching hospital; opportunity continuing studies; university medical center, south. MH2-9

STAFF AND SURGICAL—(a) Neurosurgical nurse; office, Board neurosurgeon; university city. (b) New hospital, 350 beds, affiliated medical school; staff of 75 Board men, 125 residents. (c) Surgical; small hospital; resort town, southwest; $390, maintenance. MH2-10

SUPERVISORS—(a) Operating room; modern 350-bed hospital affiliated diagnostic clinic; staff of distinguished specialists; residential town, near several large cities, east; $5000. (b) Pediatric and medical clinic supervisors; new 300-bed general hospital; college town, midwest; $400. (c) Central supply; new department; completion January; small hospital, coastal town, California. (d) Operating room and central sterilizing room; new 400-bed hospital; under American auspices; Asia; $5000. (e) Obstetrics; new 500-bed hospital affiliated university medical school; faculty rank; midsouth. (f) University respiratory center; acute and convalescent polio patients; $4500. (g) Psychiatric; new department; teaching hospital; university city, south. (h) Surgical; 200-bed hospital; new surgical suite; college and resort town, California. MH2-11



ADMINISTRATORS—(a) Medical; well-endowed Asthmatic Children's Rehabilitation Center; prefer Board pediatrician or internist, preferably with allergy or psychosomatic training; large city; mild dry climate; university medical center; $8-$12,000. (b) Lay; voluntary general hospital, 325 beds; excellent residency program; cooperative Board; lovely residential town 60,000; resort area; southeast. (c) Medical; medical center; 3 units; 350 beds; excellent medical staff; teaching program; large city; summer, winter resort area; southeast. (d) Lay; general hospital, 200 beds, city operated; southeast. (e) Lay; assistant; general hospital, 500 beds; medical school affiliated; town 150,000; east north-central. (f) Lay; general voluntary hospital, 275 beds; southwest. (g) Lay; general hospital, 225 beds; town 75,000; east. (i) Lay; voluntary general hospital, 300 beds; town 60,000; midwest. (j) Lay; voluntary general hospital, 125 beds; 100-bed expansion program in progress; New York. (k) Lay; general hospital, 200 beds; west coast. (l) Lay; assistant; special hospital; one of teaching units important medical school;

(Continued on page 218)

WOODWARD—*Continued*

New England. (n) Medical; small hospital; municipally operated; $8000; California. (o) Medical; large prepaid health organization; membership of 40,000; staffed by 40 specialists; well-equipped 100-bed hospital and large clinic; requires background in administration of large health program with experience in medical practice; $15-$20,000; large city; university medical center.

EXECUTIVE PERSONNEL—(a) Accountant and office manager; 12-man group, long established; requires one familiar with taxes and clinic-partnership accounts; California. (b) Comptroller; voluntary general hospitals; 2 units; capacity 750 beds; medical school affiliated; to $10,000; university town 150,000; east. (d) Personnel director; organize and direct department; new post; voluntary general hospital, 300 beds; northwest.

ADMINISTRATORS — NURSE. (a) Small general hospital; may set up own program; training in anesthesia helpful; resort area, southwest. (b) Small private psychiatric hospital; experience preferred; $5200, maintenance; large university center, midwest.

DIETITIANS—(a) Assistant; 400-bed general hospital; meal pack used; central service; semi-tropical city 200,000, outside United States; opportunity to advance. (b) Chief; 500-bed general hospital; new central kitchen under construction; $5000, meals; city 150,000 near New York City. (d) Dietetic consultant; for

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POSITIONS OPEN

WOODWARD—*Continued*

food management company serving many eastern hospitals; must be A.D.A. member; prefer degree in nutrition, or related subjects; some travel; $5200; large university medical center; east.

DIRECTORS OF NURSES—(a) 142-bed voluntary general hospital; will expand to 200 beds by spring; excellent personnel policies; town 37,000, southern California. (c) 190-bed tuberculosis hospital; affiliated with all hospitals for tuberculosis training; minimum $4800, maintenance, own apartment; town 120,000 near university medical center; midwest.

EXECUTIVE HOUSEKEEPERS—(a) 500-bed general hospital; about 60 in department; full responsibility; college town 120,000; east. (c) Hotel; 160 rooms; exclusive clientele; college town, bay area, California.

FACULTY POSTS—(b) Educational director; school practical nursing; experience in teaching, or degree; exclusive resort town; east. (c) Assistant director of education, advisor for collegiate school of nursing; unit large university group; faculty status; affiliated 325-bed teaching hospital; large university center.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATORS—(a) 100-bed general hospital, fully approved; located in town of 12,000 close to several large cities; $8000 to $12,000. (b) 148-bed hospital, fully approved; located in college town of about 17,000. (c) 300-bed hospital located in large eastern city; fully approved and modern in all respects; cooperative board; excellent staff. (d) Assistant administrator; 170-bed hospital within commuting distance of New York City; require good experience in public relations.

BUSINESS MANAGER—Middle west; 130-bed general hospital located in city of 50,000; hospital fully approved; good schools and adequate housing facilities; would like someone with good experience in credits, collections and accounting; $500 a month minimum to start.

PURCHASING AGENTS—(a) Middle west; 250-bed hospital located in beautiful resort area; responsible for all purchasing except dietary and pharmaceutical; $5000 minimum. (b) East; 600-bed general hospital, fully approved; 4 employees in department; purchase all supplies except drugs and food; $400 a month minimum to start. (c) Middle west; 200-bed general hospital in large city; 3 employees in department; forty-hour week.

(Continued on page 219)

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

BUSINESS ADMINISTRATORS—(a) 50-bed midwestern hospital; to build 30-bed addition. (b) New 60-bed hospital, Pennsylvania. (c) 200-bed hospital, eastern Pennsylvania.

COMPTROLLERS—(a) 450-bed eastern medical center; to $10,000. (b) Accountant; 200-bed Pennsylvania hospital.

DIRECTORS, NURSING SERVICE—(a) 350-bed hospital, east; $6000. (b) 200-bed hospital, Michigan. (c) 175-bed Ohio hospital. (d) 200-bed hospital, Virginia. (e) Sisters' hospital, Ohio; $350.

EXECUTIVE HOUSEKEEPERS—(a) 250-bed New York hospital. (b) 65-bed New Jersey hospital. (c) Large modern hospital, New England. (d) 225-bed hospital, Pennsylvania. (e) 300-bed Sisters' hospital, Ohio; excellent salary. (f) Tuberculosis sanatorium, east. (g) 400-bed hospital, Texas.

CLINICAL INSTRUCTORS—(a) Surgery; large school, Ohio; $350. (b) Pediatrics; university hospital, east; $325. (c) Orthopedics; east and west. (d) Medical nursing; midwestern university city; $400.

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

RECORD LIBRARIANS—(a) 125-bed hospital, Ohio. (b) 175-bed hospital, Pennsylvania. (c) 100-bed California hospital. (d) Philadelphia area; $300, maintenance.

NURSE SUPERINTENDENTS—(a) 30-bed new hospital, west. (b) 85-bed Illinois hospital. (c) 40-bed new hospital under construction, Ohio.

TECHNICIANS—(a) X-ray; small Florida hospital; $350; 37-hour week. (b) X-ray; 200-bed midwestern hospital; $300, meals. (c) X-ray; Ohio; $325. (d) Research; $300. (e) Hematology; university hospital, midwest. (f) Florida; $325. (g) Arizona; $350.

MEDICAL PERSONNEL EXCHANGE
Nellie A. Gealt, R.N., Director
311 Land Title Building
Philadelphia 10, Pennsylvania

ANESTHETISTS—(a) 140-bed hospital, Philadelphia area; $400 plus maintenance. (b) 250 beds; Ohio; employ several; $425 plus full maintenance.

MEDICAL PERSONNEL EXCHANGE —*Continued*

DIRECTORS OF NURSES—(a) Large hospital; east; requires top-flight young person; traveling expenses paid for interview. (b) 130-bed home and hospital; graduate staff; salary open.

EXECUTIVE HOUSEKEEPERS—(a) Large hospital; New York City; 40-hour week; salary open. (b) 225-bed hospital, western Pennsylvania; $4200.

LABORATORY TECHNICIAN—Head; male or female; 225-bed teaching hospital; ASCP registration required; starting salary $2600 plus meals and laundry.

MEDICAL RECORD LIBRARIAN—Head; large hospital; 40-hour week; $3900 plus maintenance.

PERSONNEL DIRECTOR—400-bed hospital, New England; starting salary $5000.

PHYSICIANS—(a) OB-gynecologist. (b) General practitioner; 11-man group; good hospital connections; minimum starting salary $12,000; good opportunity for advancement.

No charge for registration

(Continued on page 220)

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28 NURSES' DESKS, Stainless Steel, 24" x 36" x 31" high with 3 drawers and lock; overrun from government contract and manufactured to government specifications. Closing out at $115 each. The Punxsutawney Company, Punxsutawney, Pennsylvania.

GE MOBILE DENTAL X-RAY UNIT—Model E—CDX—115 V—60 Cycle—360° tube roxation. Tube head has M. A. Stabilizer. Excellent condition. 5 years old. $750. Contact L. C. Pullen, Jr., Administrator, Decatur and Macon County Hospital, Decatur, Illinois.

MISCELLANEOUS

WANTED: An organization, Registered Nurse as administrator, or Medical Doctor, to operate a new fully equipped 20-bed hospital in progressive city of 1500 in large agricultural and industrial area in western North Dakota. Will have full cooperation of community. Beulah Memorial Hospital Association, Beulah, North Dakota.

HOSPITAL SALESMAN WANTED

Leading manufacturer of maintenance, Sanitary and Floor Treatment Chemicals offers 5-figure per annum strictly commission opportunity to experienced salesman. Write fully: BRAMCO, 820—65th Ave., Philadelphia 26, Pa.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

CHILDREN'S HOSPITAL of Washington, D. C., offers a six months' advanced course in pediatric nursing. Classes begin (approximately) the first of April and October. Address inquiries to: Director of Nursing, Children's Hospital, 2125 13th St. N. W., Washington 9, D. C.

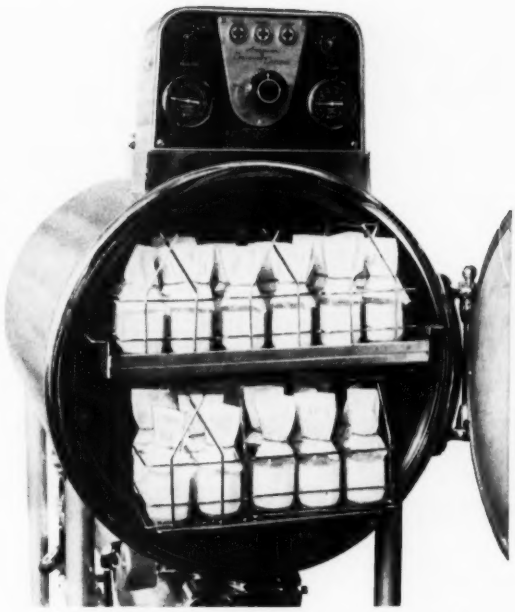
American

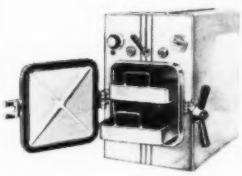
now standardizes on

Hospital sterilizers of All-welded construction

...plus

Monel Chamber, Racks and Trays





The new American all-welded sterilizers are available in a complete range of sizes. They offer the unsurpassed advantages of solid, corrosion-resisting, rust-proof Monel. Pictured above is a standard American milk formula sterilizer; at left, a small office autoclave.

The new American all-welded Monel® sterilizers save time, money and labor in any hospital...

For American's new all-welded fabrication, plus American's standardization on Monel for sterilizer chamber, racks and trays enable you to:

Cut Maintenance Costs
Facilitate Cleaning
Provide Maximum Safety

The development of all-welded construction provides a modern method of fabrication. Not only is it more efficient than methods used heretofore, but welded construction eliminates any requirement for rivet or bolt holes, or soldering. The inner shell and steam jacket are both welded to a solid wrought Monel end ring. This reduces risk of leakage, and, correspondingly, the need for safety checking.

Naturally, with chamber walls *smooth*, American's all-welded Monel sterilizers permit easier, faster cleaning. And you get maximum safety, because welding provides higher structural strength than riveting, bolting or soldering.

But that isn't all...

Monel is a lifetime metal... corrosion-resisting all the way through. No coating to peel or wear away, nothing to chip or crack. Monel withstands heat, steam and moisture as well as attacks from acids, alkalies, saline and other hospital solutions.

Moreover, it withstands hard usage because it's stronger than structural steel.

Get full information about this equipment... write directly to the American Sterilizer Company, Erie, Pennsylvania, and ask for their latest catalog.

THE INTERNATIONAL NICKEL CO., INC.
67 Wall Street New York 5, N. Y.

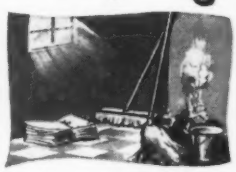
Inco Nickel Alloys

INCO

Monel... *for immunized sterilizers*

Why Risk Fire with an Oily Dressing?

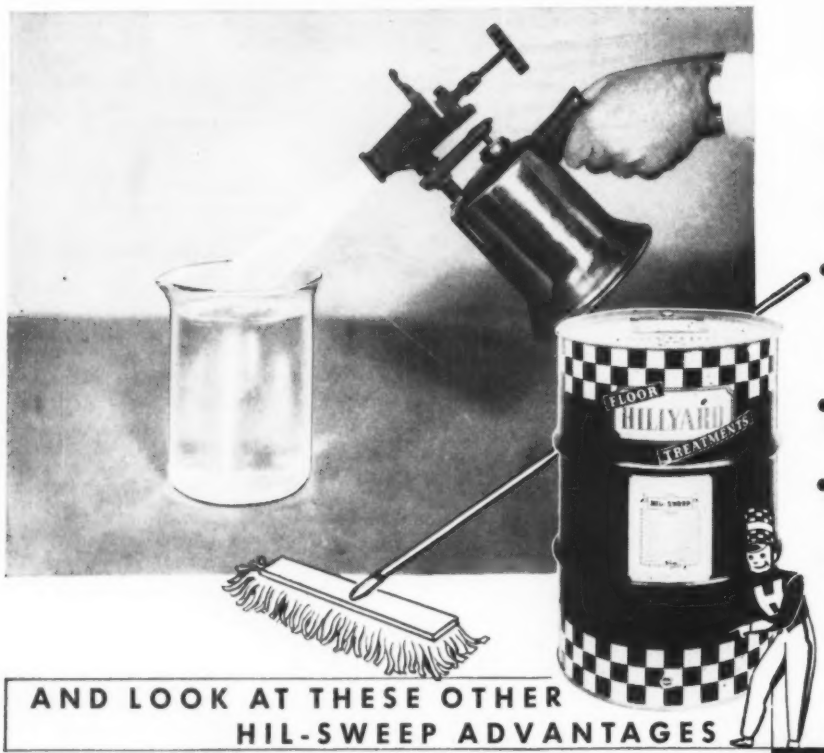
Oily dressings with even a high flash point constitute a constant fire hazard in daily use.



Mops and rags saturated with such solutions when stored often cause spontaneous combustion . . .

Presenting an ever dangerous fire threat and possible serious harm to workers and property.

HIL-SWEEP maintains floors the FLAME-PROOF way!



fire tests *PROVE* HIL-SWEEP will NOT BURN

- **Rags saturated with Hil-Sweep will not burn or cause spontaneous combustion.**
- **Eliminates fire hazard in use.**
- **Safe in storage — Won't freeze at low temperatures. Won't explode at high temperatures.**

. . . on your staff,

not your payroll.

AND LOOK AT THESE OTHER HIL-SWEEP ADVANTAGES

- Hil-Sweep is non-injurious to asphalt tile . . . the result of years of research to develop a maintainer that would be safe for daily care of resilient and all other types of floors.
- You can spray it or sprinkle it on brush, mop or dust cloth.
- Contains no emulsified oil—leaves no oily residue to darken, discolor, soften or bleed colors.
- Will not soften wax film or decrease frictional resistance.
- Won't load mop like other floor dressings. After using simply shake out brush or cloth and it's ready to use again. Saves on laundry and dry cleaning bills.
- Leaves floors cleanly fresh and dust-free, then evaporates.
- Imparts a pleasant aroma where used.

Your Hillyard Maintaineer will help you with any Floor Problem

Branches in Principal Cities.

MAIL COUPON TODAY

Hillyard Chemical Co., St. Joseph, Mo.

☐ **Please give me full information on Hil-Sweep.**

☐ **Please have the Hillyard Maintaineer make a Hil-Sweep demonstration on my floors. No charge.**

Name.....

Title.....

Institution.....

Address.....

City.....

State.....

What's New for Hospitals

FEBRUARY 1954 Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 244. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Portable Folding Stand for Flowers

The solution to where to put the patient's flowers is offered in the new Tomac Folding Flower Stand. This compact, portable stand occupies only 15 by 32 inches of floor area and has two 8 by 30 inch shelves which will hold six or more plants and vases. In addition to convenience in displaying flowers, it can be pushed into the hall at night, thus taking all flowers out of the patient's room in one operation.

The stand is treated with a rust-preventive and finished in gray Surgalum. A rim back of each shelf prevents vases and pots from being pushed off the back. Four 2 inch ball bearing swivel casters make the stand easy to move. It folds to 4½ inches wide for flat storage. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 247)**

Quick Contact Possible With Intercom System

Two new Vocatron intercom models have been introduced for quick and easy intercommunication between individuals. The Vocatron Standard and the Vocatron Long Range give faithful voice and tone reproduction. They are completely portable, can be carried from room to room and plugged into any standard electrical outlet. No additional wiring is required. Both models have noise-suppressing circuits to help maintain quiet. The new cabinets are of durable gray plastic and each consists of two units ready for use. **Vocaline Company of America, Inc., Dept. MH, Old Saybrook, Conn. (Key No. 248)**

Twin Absorber for Gas Machines

The new McKesson Twin Absorber for McKesson Gas Machines permits the removal of one canister of Baralyme and its replacement while the other is being used. Selection may be made to either canister, independent of the other. Each has its own absorption range and either canister can be changed without disturbing the circuit. **McKesson Appliance Co., Dept. MH, 2226 Ashland Ave., Toledo 10, Ohio. (Key No. 249)**

Practice Catheterization With Phantom Bladder

Constructed from synthetic rubber, the new so-called phantom bladder is of a color approximating that of normal bladder tissue. The simulated bladder has been introduced by American Cystoscope Makers for use in practicing cystoscopy

and ureteral catheterization. Various simulated pathological conditions of the bladder are shown in the model. It is mounted on a durable stand at a height convenient for study and use, and is so constructed that the top can be opened and the bladder exposed in two halves. **American Cystoscope Makers, Inc., Dept. MH, 1241 Lafayette Ave., New York 59. (Key No. 250)**

Plastic Dispenser for Plastic Band-Aids

A new white plastic dispenser has been introduced for Band-Aid Plastic Bandages. It can be hung on the wall or set on the desk and makes the bandages readily and quickly available. Each dispenser has facilities for dispensing ¾ inch Strips, 1 inch Strips, Band-Aid Patches and Band-Aid Spots. Bandages as desired are dispensed one at a time. **Johnson & Johnson, Dept. MH, New Brunswick, N.J. (Key No. 251)**

(Continued on page 226)

Food Waste Disposer for Institutions

The Toledo Model 50 Disposer is a new device for handling food waste in institutions of all kinds. It receives waste directly from soiled dishes and quickly shreds the food scraps and flushes them down the drain. There is no time wasted in the operation, and sanitation is improved. The disposer features a Reverso-Clean action which functions as a self-cleaning process. The motor automatically reverses direction each time the switch is operated.

Available for installation on sinks or tables with regular 3½ to 4 inch openings, the disposer can be equipped with stainless steel cone and rubber scrapping block. It is also available with silverware guard. **Toledo Scale Co., Dept. MH, 245 Hollenbeck St., Rochester, N.Y. (Key No. 252)**

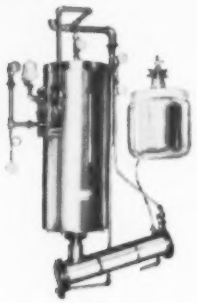
Beautyrest Sofa Bed for Dual-Purpose Rooms

Designed for sleeping rooms which can double as living rooms, the new Simmons Beautyrest Sofa Bed is suitable for nurses' homes and other personnel housing. The sofa bed gives the comfort of the Beautyrest Mattress for sleeping. It is full twin bed size and has a specially reenforced box spring mounted on a sturdy welded steel frame. Closed, the sofa bed is the right height and depth for comfortable seating. Special construction prevents the bed from sliding forward. To open, the bed moves out on silent casters and is easily prepared by simply removing the slip cover.

The Zalmite topped backrest provides space for pillows and blankets. **Simmons Company, Dept. MH, Merchandise Mart, Chicago 54. (Key No. 253)**

What's New . . .

Water Still Produces 15 Gallons Per Hour



Removing all types of impurities from water, including pyrogens, the new Barnstead 15 produces 15 gallons of distilled water per hour. It was developed to meet the increased requirements of hospitals for distilled water at small additional cost. The unit features a special demountable type condenser which is easily disassembled for cleaning. Cooling water tubes used in condensing the steam may be exposed, making it possible to clean out scale. The new unit is wall-mounted and includes a Pyrex tank. **Barnstead Still & Sterilizer Co., Dept. MH, 2 Lanesville Terrace, Forest Hills, Boston 31, Mass. (Key No. 254)**

Conductive Adhesive for Ceramic Tile

Conductive Adhesive has been developed for setting conductive ceramic tile flooring in operating and surgical suites. The adhesive meets all requirements of the National Fire Protection Association, recommended safe practice for hospital operating rooms, according to the manufacturer. It provides a simplified noiseless and dustless method of installing conductive tile floors, and has electrically conductive properties required for safe operation. **Miracle Adhesives Corp., Dept. MH, 214 E. 53rd St., New York 22. (Key No. 255)**

"Golden Tone" Ekotape Provides Two Speed Recording

The "Golden Tone" Ekotape is a new model tape recorder designed to play at either 7½ or 3¾ inches per second. A single switch selects the speed desired and provides the necessary compensation within the amplifier for the change in speed. Functional styling is combined with modern appearance in this compact, lightweight unit. Input and output jacks and all controls are grouped at the back of the top panel for easy accessibility. The unit is easy to service, with a minimum number of moving parts, yet provides a range of combinations enabling the listener to set the tone precisely to his taste.

The new model provides either manual or foot control for instantaneous starting and stopping during recording and playback. A convenient pocket in the cover of the case furnishes storage for microphone and cord and reels of tape. The case is finished in plastic in hunter green and silver gray. **Webster Electric Co., Dept. MH, 1900 Clark St., Racine, Wis. (Key No. 256)**

Talking Window Is Draftproof

A circular window is being introduced through which one can speak and hear, but which is draftproof and germproof. Developed in Europe, the Looky-Talky Window consists of a membrane which transmits sound as if there were no window at all. A carrying frame supports the membrane and is inserted into the outside rims which support the complete unit. The talking window can be set in a wall or in a glass window where communication between the two areas is desired. Clear and distinct voice transmission is afforded by the window, which is suitable for use in business offices,

cashier's offices, reception rooms and other locations. A metal disc is provided for insertion when the window is not being used. **Sun-Sash Company, Dept. MH, 38 Park Row, New York 38. (Key No. 257)**

Silver King Cleaner Provides Wet or Dry Pickup

A new wet or dry vacuum cleaner has been developed to sell at a low cost, yet to give efficient service. The Silver King is a combined wet and dry pick-up vacuum cleaner which will handle 2½ gallons wet and over 4½ dry. It is a light weight unit which has high power and is designed for use in offices and areas where the cleaning job is limited in scope. It is of rustproof, all aluminum construction with an all rubber, non-kinking hose. The cleaner moves on sturdy, smooth gliding casters and there are 13 cleaning attachments and accessories available to make it an all around cleaner. **Ross & Story Products Corp., Dept. MH, Dewitt St., P. O. Box 12, Syracuse, N.Y. (Key No. 258)**

(Continued on page 228)

Continuous Nebulator for Oxygen Tents and Masks

The Eliot Neb-(EL)-izer is a complete low cost cool humidity continuous nebulator for oxygen tents and face masks. It was specifically designed for cool aerosols and requires only one oxygen or air supply, using one regulator. It was designed to facilitate the treatment of severe respiratory disorders when used with cold vapors of water or detergents as aerosols. It provides air or oxygen super-saturated with a fog of uniform fine aerosol particles. The plastic bottle reservoir has a capacity of 500 cc., assuring continuous aerosols over prolonged periods of time. It is a complete, low-cost unit which operates without electrical or mechanical controls. **Eliot Medical Plastics, Inc., Dept. MH, 429 Washington St., Lynn, Mass. (Key No. 259)**

Direct-Writing Cardiotron Offers Positive Improvements

The Cardiotron PC-3 is an improved model direct-writing electrocardiograph. It features the lead-marking system, the new positive polarity indicator, the improved Auto-Prestomatic Switch and a new internal grounding system. The new features provide greater convenience for the operator, increased diagnostic function, more positive control and important time-saving factors through easier usage and record interpretation.

The unique lead-marking system in the new instrument prints any of the ten standard leads being taken without resorting to codes or multiple actuation of a marker button. It obviates the possibility of misinterpreting the lead legend or of incorrectly marking a lead. The new positive operating power line polarity indicator assures proper connection to the power line. The new switch system operates rapidly and positively and the improved circuit provides freedom from electrical interference. There are

other improvements in the Cardiotron PC-3 including lighter weight. **Electro-Physical Laboratories, Inc., Dept. MH, Stamford, Conn. (Key No. 260)**

What's New . . .

1954 Designs in Hollister Birth Certificates

Many new designs have been added to the Hollister Birth Certificate selection for 1954. The designs include modern, traditional and religious motifs. A new folder style certificate has been designed at the request of hospitals desiring smaller size in Birth Certificates. Several of the new folder style certificates feature a photograph of the hospital with the design planned to harmonize with the style of architecture of the building. They are also available without a picture. **Franklin C. Hollister Company, Dept. MH, 833 N. Orleans St., Chicago 10. (Key No. 261)**

Camera Films Single Sheet or Bulky Originals

A new microfilm camera has been developed which films single sheets, magazines, bound volumes with pages spread open, notebooks and other bulky originals without removing the pages, in all sizes up to 11 by 17 inches. Known as the Film-A-Record Model No. 4 Microfilm Camera, the machine can be operated at speeds up to 1500 exposures an hour.

A Visual Supply Indicator shows at a glance the amount of film left in the camera, while an audible signal warns when the film has been loaded improperly, when the take-up reel is full, or when the film fails to advance properly. Film is easily loaded or removed without

technical training, and a foot switch controls the operation of photographing documents and advancing the correct amount of film. A colorstat permits increasing or decreasing light intensity for photographing original documents of varying color. **Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 262)**

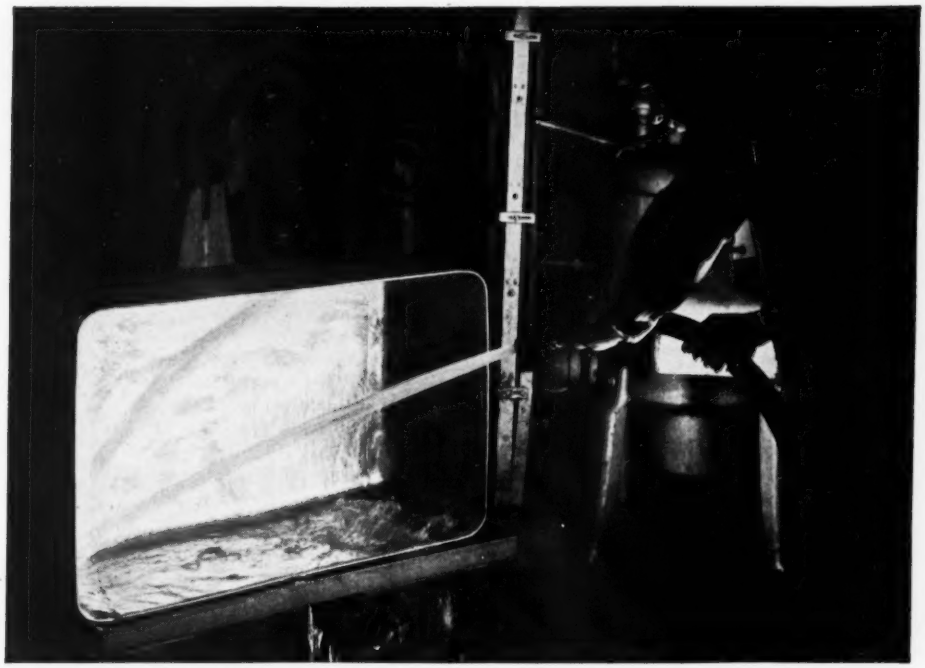
Liquid Detergent for Cleaning Glassware

Laboratory and clinical glassware can be cleaned effectively with the new 7X Detergent. It is a concentrated liquid which comes in standard, factory controlled strength and is not influenced by local storage conditions or mixing practice variations. It is prepared by simply mixing with water. Glassware is quickly and easily cleaned. Laboratory glassware to be used for tissue examinations and culture growth rinses clean without salts or sediment deposits or adherence, according to the manufacturer, when washed in 7X. **Linbro Chemical Co., Dept. MH, 681 Dixwell Ave., New Haven 11, Conn. (Key No. 263)**

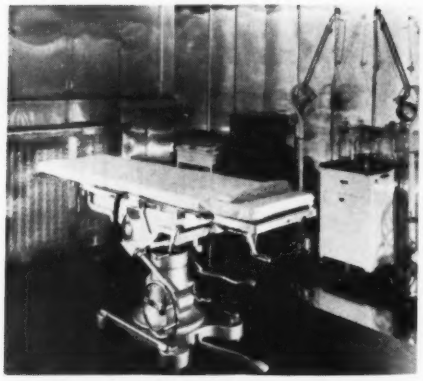
Apron and Glove Rack for X-Ray Laboratory

Quality construction and attractive design have been combined in the new Halsey Apron and Glove Rack for the x-ray laboratory. It is constructed of heavy gauge metal with all sharp edges and corners eliminated to prevent tearing or breaking of lead aprons and gloves. The glove standards are topped with attractively colored plastic spheres and permit easy storage and maximum ventilation of the inside of the glove. The apron holder prevents the possibility of bending or cracking of lead aprons when stored, and affords easy accessibility. **Halsey X-Ray Products, Inc., Dept. MH, 1425 Thirty-Seventh St., Brooklyn 18, N.Y. (Key No. 264)**

(Continued on page 230)



ENDURO HOSPITAL EQUIPMENT CLEANS AS EASILY AS THIS



Even the walls of this operating room are ENDURO! *Hospital equipment manufacturers are featuring a wide variety of standard and custom-built items made of easy-to-care-for* ENDURO *Stainless Steel.*

● The ease with which this ENDURO Stainless Steel container is cleaned will interest everyone who uses metal equipment. A simple rinsing with water and wiping down usually restores ENDURO surfaces to sparkling cleanliness.

What makes ENDURO so remarkably easy to clean and to keep clean? It is solid stainless steel, with no applied surface to chip, peel or crack. It is strong, tough, durable. Takes quite a knocking around without coming up dented or abraded. It resists rust and corrosion, and the action of most acids and alkalies. Result: ENDURO hospital equipment maintains a smooth, hard surface. Residue and contaminants have little foothold. They flush away.

Think what this ease of cleaning can mean . . . in man-hours saved . . . in improved employee morale . . . in a brighter, more cheering atmosphere . . . in economy of operation. Ask your supplier, or write Republic for help in applying ENDURO to your equipment needs.

REPUBLIC STEEL CORPORATION
Alloy Steel Division • Massillon, Ohio
GENERAL OFFICES • CLEVELAND 1, OHIO
Export Department: Chrysler Building, New York 17, New York

REPUBLIC
ENDURO STAINLESS STEEL

Other Republic Products include Carbon and Alloy Steels—Pipe, Sheets, Tubing, Lockers, Shelving, and Fabricated Steel Building Products

What's New . . .

Plastic Binding Unit for Desk-Top Use

The PB-5 Combo is a desk-top unit for low-cost plastic binding that can be used even in a small institution. It handles both punching and binding operations on the same machine, thus simplifying the procedures. Loose sheets of all sizes and types can be quickly and easily plastic bound with the new machine. The unit is compact and easy to handle. It punches ten to fifteen pages at a time and is built for years of service without maintenance. It occupies a minimum of space on a desk and fits into a desk drawer. **General Binding Corp., Dept. NS, 812 W. Belmont Ave., Chicago 14. (Key No. 265)**

Dual-Pak Containers For Cleaners

Storage space is reduced considerably with the new Dual-Pak containers now used for five of the leading Wyandotte cleaners. Sturdy cartons enclose the waterproof polyethylene liners which are easily opened but prevent the entrance of moisture. Each container holds 20 or 25 pounds of the cleaning product, providing a control package. The new packages are shipped in sturdy three color, easily identified cases, each containing three of the Dual-Pak cartons. **Wyandotte Chemicals Corp., Dept. MH, Wyandotte, Mich. (Key No. 266)**

Complete Selection of Graduated Cylinders

A complete selection of quality graduated cylinders has been added to the Propper laboratory supply line. Crown Brand graduated cylinders are made of chemical resistance glass for safety, have large ground bases for stability, and are individually calibrated for accuracy. All markings are blue, fused-in, acid-resisting type for lifetime legibility. **Propper Manufacturing Co., Dept. MH, 10-34 44th Drive, Long Island City 1, N.Y. (Key No. 267)**

Versatile Design In Acoustical Tile

Many unusual ceiling effects can be obtained from one pattern with the new Grosgrain Tile. This Acoustone mineral acoustical tile is but one of many developed by the company to provide attractive effects. Motif'd Acoustone can be installed by mechanical suspension to give access to areas above ceilings if desired. It can be applied to wood furring, over existing ceilings or to exposed wood joists. **United States Gypsum Co., Dept. MH, 300 West Adams St., Chicago 6 (Key No. 268)**

Catheter Clamp Is Expendable

A completely leakproof, nonslip closure of the inflation channel of balloon catheters is possible with the new expendable V-Clip Catheter Clamp recently introduced. It is made of sturdy but pliable aluminum for instant application and removal and is negligible in cost. The V-Clip is attached with light hand pressure, providing an effective stoppage

without damage to catheters. It is as easily removed. **United Surgical Supplies Co., Dept. MH, 650 Halstead Ave., Mamaroneck, N.Y. (Key No. 269)**

(Continued on page 232)

What's New . . .

Desk Telephone Requires No Power

Wheeler Telephone Systems require no batteries and no connections to outside power sources. Current necessary for voice transmission is generated by the voice itself through an electro magnetic unit. The telephone instruments are operated in essentially the same manner as standard telephone or intercom equipment. The ringing signals are also transmited by self-generated electric current. Where noise is a factor the instruments may be equipped with neon lights as visual indicators. A new Executive Cradle-Type Desk Telephone Unit is now being introduced into the Wheeler line. The instruments in the new set are particularly designed for use in modern offices and equipment is comparable in design, size and quality of construction with standard telephone desk sets.

The new set was developed especially to meet the need for additional private communication between executive offices or between executive offices and specified areas. It does not take the place of regular office intercom equipment. The Cradle-Type instruments are designed to provide communication with a maximum of two other stations. **The Wheeler Insulated Wire Co., Dept. MH, 1129 East Aurora St., Waterbury 20, Conn. (Key No. 270)**

Display Rack for Magazines Simplifies Handling

Popular sized magazines and periodicals can be displayed for easy reference in libraries or waiting rooms with the

new Halverson Magazine Rack. The 20-P is an all-steel rack designed to fit into any room decoration. It has space for displaying 30 popular sized magazines and newspapers. The dividers and pockets are designed with a backward tilt to protect the publications from bending forward, thus ensuring neatness and simplifying selection and handling. The new rack is 30 inches high and takes up a minimum amount of floor space for the number of publications displayed. It is finished in baked-on gray hammerloid enamel. **Halverson Specialty Sales, Dept. MH, 1219 W. Chestnut St., Chicago 22. (Key No. 271)**

Flush Door Surface with Concealed Hinge

Free swinging action combined with simple and accurate control are provided with the new type of toilet compartment door hinge suspension. The full suspended load and weight of the door rests on a frictionless-type thrust ball bearing. This new type of suspension, plus the needle rollers in the bearing of the upper hinge, have reduced friction so that the merest touch moves the door in any direction indicated. A bronze adjustment bushing at the base of the bottom hinge provides positive adjustment for swing of door, rest position of door and vertical adjustment of door. This permits the door to be set for rest position at any desired angle. Operating parts of the hinge are concealed within the door itself, resulting in a neat appearance and easily cleaned flush surface. Parts are thus protected from moisture and dirt, and from theft or vandalism. **The Sanymetal Products Co., Inc., Dept. MH, 1677 Urbana Rd., Cleveland 12, Ohio. (Key No. 272)**

(Continued on page 234)

What's New . . .

Drawn Steel Wheels for Heavy Equipment

A new series of drawn steel wheels for use in institutions and other areas with hard usage, have been added to the Faultless Caster line. They have a load rating nearly double that of cast wheels and are available in 4, 5 and 6 inch sizes. The flat tread withstands shocks and a snug-fitting dust cap keeps out dirt and retains lubricant in the bearing. **Faultless Caster Corporation, Dept. MH, Evansville, Ind. (Key No. 273)**

Vegetable Peeler in Portable or Floor Model

The Univex Deluxe Model D Stainless Steel Vegetable Peeler features a new

bearing assembly, a new Tumblelator peeling disc, a new type ⅓ h.p. electric motor and a newly designed long-life automatic timer. It is available in a light weight portable model or in a heavy duty floor model. The portable model can be placed on counter, table or drainboard with no clamps, bolts or peel trap. Twenty pounds of potatoes or other root vegetables can be poured into the unit and peeled in one minute. The pulverized peel will flow down the sink drain without clogging, or a peel trap may be used if desired. The automatic timer prevents over-peeling. **Universal Industries, Dept. MH, Somerville, Mass. (Key No. 274)**

Pads Add Protection And Comfort

The new 22 inch No. 656 Kotex Protective Pad is 15 percent thicker than earlier pads. It is softer and fluffier and is designed to be more stain resistant and leakproof. The new maternity pads provide greater comfort and protection to the patient and less opportunity for soiled linens. The process for producing the Cellucotton "fluff" used as the inner material in the pad has been changed giving lighter and fluffier fibers which eliminate the possibility of lumps, add to the thickness of the pads, and offer greater protection. The crepe wrapper runs lengthwise in the new pad thus reducing the risk of stains on the side. **Bauer and Black, Dept. MH, 309 W. Jackson Blvd., Chicago 6. (Key No. 275)**

Continuous Film Projection for Long Stay Patients

A new device which permits the continuous projection of films, without rewinding, for more than 200 hours in undarkened rooms is now available. It has been used in hospitals having long stay patients with interesting results, according to the manufacturer. The machine provides "push-button movies" in color or black and white and includes both projector and screen in one unit. It can be set up in a ward or recreation room and runs without attention for long periods of time. **Triangle Continuous Projector Co., Dept. MH, 3706 Oakton St., Skokie, Ill. (Key No. 276)**

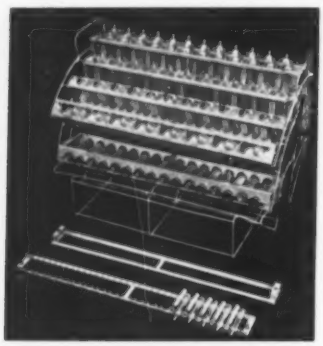
(Continued on page 236)

What's New . . .

Easy-Load Racks On James Syringe Washer

The James portable hypodermic syringe washer is fully automatic in operation. It features easy-load racks which are quickly removable for filling and unloading. They are specially designed so that barrel and plunger are loaded together, making it easy to reassemble after cleaning.

The washer is fully portable and requires no plumbing or wiring. The machine is rolled up to the sink, the hose is snapped on the faucet, the cord plugged into a regular electric outlet and it is ready for operation. Loaded racks are put into the machine, it is set, and the complete 9½ minute wash and double rinse cycle is carried through automatically, the machine shutting itself off when it is completed. Depending on size, the machine handles 147 to 238 syringes at one washing. It is 30 inches high, and 17½ by 24¾ inches in area. The wash well is of stainless steel and the cabinet is of gray bonderized steel with glass top. **James Manufacturing Co., Dept. MH, Independence, Kans. (Key No. 277)**



Labelon Typewriter Tape for Typewriter Use

Labelon Tape for marking any smooth, clean surface, is now available for typewriter use. The flat labels, affixed to smooth-finished backing sheets, are now bound in tablet form. The new tape can be written on with any dry, blunt point as well as with a typewriter. The writing or typing is permanent and does not fade or come off. **Labelon Tape Company, Inc., Dept. MH, 450 Atlantic Ave., Rochester 9, N.Y. (Key No. 278)**

Clinical Camera Is Easy to Operate

Accurate color photographs for diagnosis, record or teaching purposes can be easily taken with the new Knebel 35 mm. Clinical Camera. The new instrument was developed in consultation with and tested by physicians and surgeons. The camera has only five moving parts. Focusing, lighting and adjustment are simplified so that the camera can be operated with successful results by those unfamiliar with even the elements of photography. It produces 2 by 2 inch color slides which may be studied in a viewer, projected onto a screen, or made into large color prints.

The camera is equipped with its own light source which is built to last for ten thousand pictures before replacement. The speed of the flash stops motion, ensuring results even with children. Accurate positioning is facilitated by lights within the camera itself. The camera may be used on its own stand, mounted on a tripod or held in the hand. **Knebel Electro-Optical Instruments, Dept. MH, 317 Rhinecliff Drive, Rochester 18, N. Y. (Key No. 279)**

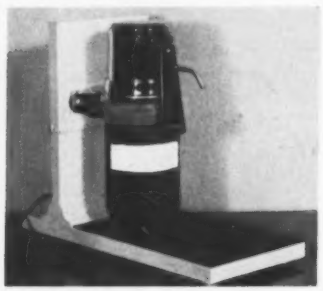
(Continued on page 238)

What's New . . .

Instant Coffee for Individual Service

Instant Maxwell House Coffee is now available in individual service envelopes for institutional use. Each envelope contains enough for one cup of coffee which is quickly and easily prepared at the time of need. Supplies kept in floor kitchens will simplify the preparation of coffee as needed. **General Foods, Dept. MH, 250 Park Ave., New York 17. (Key No. 280)**

Soap Dispenser Is Electric Powered



The Flomatic Soap Dispenser is electric powered. A touch of the finger starts the small, silent pumping unit and the soap flows into the palm of the hand. It is designed for use where sanitation is important, and should be especially appropriate for installation in rest rooms used by patients as well as rest rooms and other areas where personnel wash their hands.

The dispenser is attached to the wall surface by means of a specially designed adhesive plate which requires no drilling of holes into the wall. Finished in heavy chrome plate, the dispenser is attractive in design and general appearance, and is easily kept clean. **James Varley & Sons, Inc., Dept. MH, 1200 Switzer Ave., St. Louis 15, Mo. (Key No. 281)**

Quick Heat to Remote Radiators

Remote radiators, mains, risers and cold areas can be quickly heated without the necessity of overheating the entire system with the Heat-Timer Varivalve. A heavy-duty phosphor bronze bellows inside the patented all purpose air valve provides positive closing of a large venting orifice, thus assuring rapid venting. The venting return can be varied to meet requirements, thus bringing heat quickly to places of need and resulting in fuel saving.

When Varivalves are used to replace ordinary valves the orifice can be adjusted for a perfect balance throughout the heating system. Operation is noiseless and there is no hissing or cracking. Varivalve is designed to operate on any one inch steam system. **Heat-Timer Corp., Dept. MH, 657 Broadway, New York 12. (Key No. 282)**

Built-In Locker Lock Has Improved Engineering

The new 68-267 is a masterkeyed, built-in locker lock of sturdy construction. It offers locker security and long life because of the engineering improvements which provide great durability and trouble-free performance. It has a heavier, flat bolt cap for simplified construction, guaranteed uniform, easy action and increased strength. The bolt cap is held firmly in place by shoulders on screw posts below and by bushings above. The bolt pawl and floating bolt are both of new design. A similarly constructed lock without the master key feature is also available. Master keys for the new 68-267 may be interchanged with older National locker locks of the same code. **National Lock Co., Dept. MH, Rockford, Ill. (Key No. 283)**

(Continued on page 240)

Vina-Lux®

PERFECT RECIPE FOR ABUSE-PROOF FLOORS

Vina-Lux vinyl asbestos tile is amazingly abuse-proof and remarkably greaseproof. It's a tile with a surface that's smooth as silk, tight as a drum and tough as nails. It gives you a floor that doesn't need special care—that refuses to be damaged by spilled foods, vegetable greases and oils. A floor that requires no old-fashioned hard scrubbing, but asks only for a quick mopping to keep it bright and sanitary.

Because it has a springy, resilient structure, Vina-Lux brings welcome foot and leg ease, too—makes employees' work hours more pleasant, less fatiguing.

While Vina-Lux serves with distinction in any food preparation or serving area, its colors are so beautiful they put any area of the hospital on dress parade. In its comprehensive range of 20 marbleized and solid colors are today's lightest, brightest and most modern colors—the most desirable and complete range of colors available.

Vina-Lux may be laid on concrete, on, above or below grade. Dollars invested in Vina-Lux for hospital floors will pay off in extra years of wear, extra good looks, extra ease of maintenance. It's the tile with *all* the extras.

Learn more about America's leading vinyl asbestos tile—send for Vina-Lux color chart and product data.

AZROCK PRODUCTS DIVISION • UVALDE ROCK ASPHALT CO.
FROST BANK BUILDING • SAN ANTONIO, TEXAS • MAKERS OF VINA-LUX • AZROCK • DURACO • AZPHLEX

AZROCK FLOORING PRODUCTS

What's New . . .

Pharmaceuticals

Quelicin Chloride

Quelicin Chloride is a short acting muscle relaxant of low toxicity for general surgical procedures. Onset is rapid and duration of action is short. Thus the product is also beneficial for administration at the end of surgical procedures where added relaxation is desired. It is supplied in 10 cc. multiple-dose vials and in 10 cc. ampouls. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 284)**

Achromycin

Achromycin is a broad-spectrum antibiotic with wide therapeutic usefulness. It is effective in gram-negative infections and gram-positive infections. It is immediately soluble, has high absorbability, resulting in high blood levels rapidly attained, and is highly stable. Minimal gastrointestinal irritation was observed in preliminary trials, indicating high tolerance. The product is supplied in capsule form, 50 mg., 100 mg., 250 mg.; and in intravenous vials of 100, 250 and 500 mg. **Lederle Laboratories Division, American Cyanamid Company, Dept. MH, 30 Rockefeller Plaza, New York 20. (Key No. 285)**

Levo-Dromoran

Levo-Dromoran Tartrate is a synthetic narcotic with properties similar to those of morphine but it is more potent and usually longer acting. It is highly effective on oral as well as on subcutaenous administration. It is indicated for the relief of severe pain. It is also useful for preoperative medication and postoperative pain relief. **Hoffmann-LaRoche Inc., Dept. MH, Roche Park, Nutley 10, N.J. (Key No. 286)**

Nitranitol R. S.

Nitranitol R.S. combines the direct vasodilating action of Nitranitol with the dual hypotensive and sedative actions of Rauwolfia. It is designed for use in the treatment of essential hypertension. **The Wm. S. Merrell Company, Dept. MH, Cincinnati 15, Ohio (Key No. 287)**

Solanital B-C Capsules

Solanital B-C Capsules are a balanced mixture of natural anticholinergic alkaloids plus B complex vitamins and vitamin C. The product has a spasmolysis-sedative action and provides generous amounts of water soluble vitamins. The product combines natural alkaloids with extracts of belladonna and hyoscyamus. Phenobarbital is included to reduce the threshold of cortical irritability and thus minimize emotional reaction. **Smith-Dorsey, Dept. MH, Lincoln, Neb. (Key No. 288)**

Penicillin-PBZ

Penicillin-PBZ combines in a single oral tablet the antibiotic action of potassium penicillin G (200,000 units) with the anti-histaminic effect of Pyribenzamine (25 or 50 mg.). The new tablets offer the advantages of high strength oral penicillin with an antihistamine, which has been shown to minimize or prevent sensitivity reactions to penicillin. **Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N.J. (Key No. 289)**

K-Cillin

K-Cillin is a formulation of potassium penicillin in a stable suspension for oral administration. The palatable flavored liquid suspension eases the problem of administration to children and can be used wherever oral penicillin treatment is prescribed. The K-Cillin formulation will not require refrigeration. **Bio-Ramo Drug Company, Dept. MH, Baltimore 1, Md. (Key No. 290)**

(Continued on page 244)

Mechanized Handling

saves you Manpower, Money, Minutes on Extraction of loads totalling in the tons.

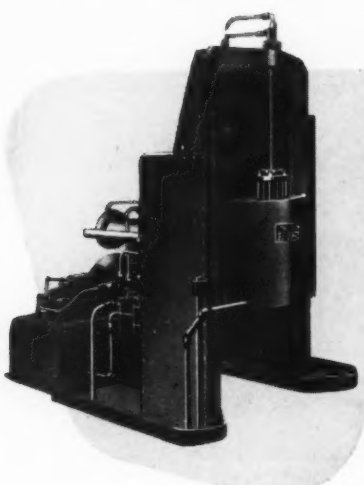
More and more—laundry operators are finding it's "penny wise, pound foolish" to handle daily tonnage manually at extractors. Modern mechanical equipment speeds production and cuts cost by processing loads on a bulk basis. Avoids delays and bottlenecks—avoids high, non-productive labor charges. Now investigate how you can increase profits on every pound of work with Hoffman "mechanized handling" Extractors.

HOFFMAN

UNLOADING EXTRACTORS

in 50, 54 and 60-Inch Diameters

or...



the fast-cycle

HYDRAULIC EXTRACTOR

for 2,500 Pounds Per Hour

With unloading extractor, above, two basket halves of wet work are lifted by electric hoist—deposited directly into extractor. Then, extracted load is raised, rolled via overhead monorail, and dumped for tumbling or flatwork finishing.

Hydraulic Extractor provides 5-minute cycle for loading, extracting and unloading. 200-pounds per run. Quiet—vibration free—simple, single-lever control.

INSTITUTIONAL ... DIVISION

Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

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USE THIS CARD

(We pay the postage)

This card is detachable and is provided for the convenience of our subscribers, and those to whom they pass their copies, in obtaining information on products and services advertised in this issue or described in the "What's New" Section. See reverse side.

February, 1954

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

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INSTITUTION _____

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SEC. 34.9 P. L. & R.
CHICAGO, ILL.

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THE MODERN HOSPITAL

919 NORTH MICHIGAN AVENUE

CHICAGO 11, ILLINOIS

Colorful CASSEROLE COOKERY

OVAL FISH CASSEROLE

OVAL CASSEROLE—HANDLED

SAF HANDLE CASSEROLE

NEW YORK CASSEROLE

ROUND CASSEROLE

INDIVIDUAL STEW POT—HANDLED

INDIVIDUAL CASSEROLETTE

FRENCH CASSEROLE—SIDE HANDLED

Use the appeal of a beautiful color in your casserole service. Clear, brilliant Hall underglaze colors, fused with body and glaze by our single-fire process, will not fade or wear away. Your choice of color is available in all Hall China . . . casseroles, baking dishes, coffee and teapots, creamers, jugs, ash trays, and many other items. Write for color chart.

27 POPULAR HALL UNDERGLAZE COLORS

Black	Canary	Emerald Green	Lustre Marine	Rose		Turquoise
*Blue	Clay	Flesh	Ivory	Maroon	Sandust	Violet
Brown	Delphinium	Gray	Lettuce	Orchid	Sea Spray	Yellow
Cadet	Dresden	Green	Lune Blue	Pink	Tan	*as illustrated

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

Hall China Casseroles are available in sizes ranging from individual to banquet service.

Each Hall Casserole is individually hand finished, by a skilled craftsman, before glaze is applied.

Index to Products Advertised—*Continued*

Colorful CASSEROLE COOKERY

Use the appeal of a beautiful color in your casserole service. Clear, brilliant Hall underglaze colors, fused with body and glaze by our single-fire process, will not fade or wear away. Your choice of color is available in all Hall China . . . casseroles, baking dishes, coffee and teapots, creamers, jugs, ash trays, and many other items. Write for color chart.

27 POPULAR HALL UNDERGLAZE COLORS

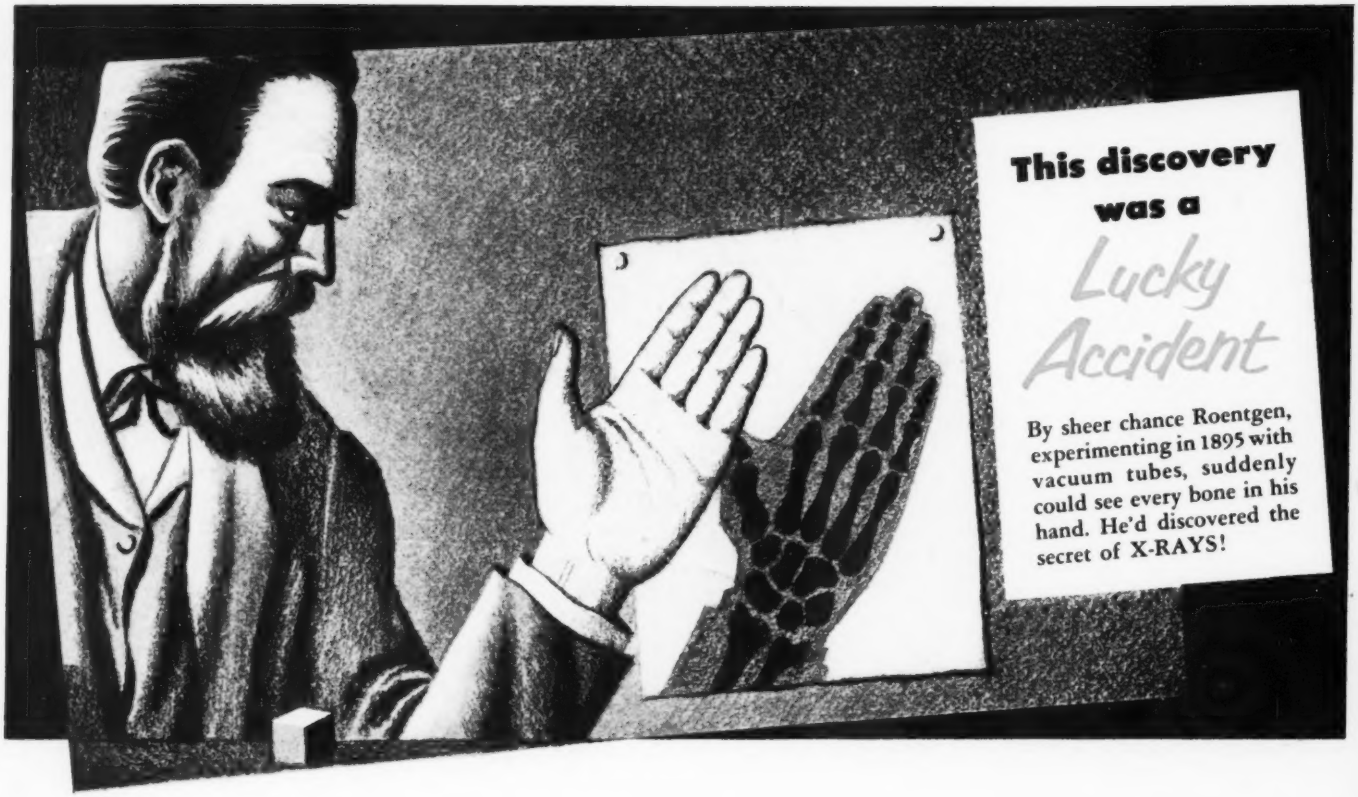
Black	Canary	Emerald Green Lustre	Marine	Rose	Turquoise
*Blue	Clay	Flesh	Ivory	Maroon	Sandust	Violet
Brown	Delphinium	Gray	Lettuce	Orchid	Sea Spray	Yellow
Cadet	Dresden	Green	Lune Blue	Pink	Tan	*as illustrated

THE HALL CHINA COMPANY · EAST LIVERPOOL, OHIO

The World's Largest Manufacturer of Fireproof Cooking China

Hall China Casseroles are available in sizes ranging from individual to banquet service.

Each Hall Casserole is individually hand finished, by a skilled craftsman, before glaze is applied.



But *Increased Profits* are no accident

when you have Gumpert Quality Insurance Gumpert Cost Control in Restaurant Operation

Profit leaks such as spoilage, waste and high food costs rob restaurant operators of real money. These "hidden" profit leaks *can* be plugged, however, by Gumpert Food Specialties which insure quality and control cost.

Gumpert's prepared Food Specialties eliminate the risk of costly failure and cut down valuable preparation time, too. In addition, Gumpert products insure standardization and yield consistently perfect results.

Next time your Gumpert Field Man calls, ask him to show you how Gumpert products assure *cost control with quality insurance*...help you get those "hidden" profits and build a bigger demand for the food you serve. You'll be glad you did!

S. GUMPERT CO., INC. • JERSEY CITY 2, N. J.
CHICAGO • SAN FRANCISCO

GUMPERT

300 Quality Food Specialties For The Restaurant Industry

Have YOU tried GUMPERT'S

Beef Base
Chicken Base
Onion Soup
Spaghetti Sauce
Cake Mixes
Chiffon Pie Filling
Gelatine Desserts
Puddings

GUMPERT Products are obtainable only direct from the maker through GUMPERT FIELD MEN specially trained to help you use them profitably.